		FOR BHF USE			

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IMPORTANT NOTICE

THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

2013
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT) FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2013)

I. IDPH License ID Number: 0027870

Facility Name: St Agnes HC and Rehab Center

Address: 1725 South Wabash (Number) — Chicago (City) — 60616 (Zip Code)

County: Cook

Telephone Number: (312) 787-9400 **Fax #** (312) 787-9590

HFS ID Number:

Date of Initial License for Current Owners: 07/26/83

Type of Ownership:

VOLUNTARY, NON-PROFIT	PROPRIETARY	GOVERNMENTAL
[ ] VOLUNTARY, NON-PROFIT	[X] PROPRIETARY	[ ] GOVERNMENTAL
[ ] Charitable Corp.	[ ] Individual	[ ] State
[ ] Trust	[ ] Partnership	[ ] County
IRS Exemption Code ____	[ ] Corporation	[ ] Other ____
	[X] "Sub-S" Corp.	
	[ ] Limited Liability Co.	
	[ ] Trust	
	[ ] Other ____	

In the event there are further questions about this report, please contact:
Name: Peter O'Brien Telephone Number: (312) 787-9400
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/13 to 12/31/13 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed)	(Date)
	(Type or Print Name)	
	(Title)	
Paid Preparer	(Signed)	(Date)
	(Print Name and Title)	Steven F. Lutz Partner
	(Firm Name & Address)	Wolf & Company LLP 1901 S. Meyers Road, St 500 Oakbrook Terrace, IL
	(Telephone)	(630) 545-4500 Fax # (630) 574-7818

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number St Agnes HC and Rehab Center # 0027870 Report Period Beginning: 01/01/13 Ending: 12/31/13

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	171	Skilled (SNF)	171	62,415	1
2		Skilled Pediatric (SNF/PED)			2
3	26	Intermediate (ICF)	26	9,490	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	197	TOTALS	197	71,905	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	40,661	1,111	10,266	52,038	8
9	SNF/PED					9
10	ICF	3,651	297	46	3,994	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	44,312	1,408	10,312	56,032	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.93%

D. How many bed-hold days during this year were paid by the Department? None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 01/01/1993

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 01/01/1993 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 171 and days of care provided 4,982

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2013 Fiscal Year: 12/31/2013

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number St Agnes HC and Rehab Center # 0027870 **Report Period Beginning:** 01/01/13 **Ending:** 12/31/13

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	422,646	54,847	112,014	589,507		589,507	111,387	700,894			1
2	Food Purchase		503,669		503,669	(65,477)	438,192	(1,234)	436,958			2
3	Housekeeping	289,100	103,114	1,918	394,132		394,132		394,132			3
4	Laundry	190,347	43,870		234,217		234,217		234,217			4
5	Heat and Other Utilities			258,576	258,576		258,576	3,695	262,271			5
6	Maintenance	169,721		155,455	325,176		325,176	56,865	382,041			6
7	Other (specify):*	69,650			69,650		69,650		69,650			7
8	**TOTAL General Services**	1,141,464	705,500	527,963	2,374,927	(65,477)	2,309,450	170,713	2,480,163			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	2,989,330	527,674	756,730	4,273,734		4,273,734	624,522	4,898,256			10
10a	Therapy	75,689		550,484	626,173		626,173		626,173			10a
11	Activities	166,226	13,738	34,752	214,716		214,716	33,343	248,059			11
12	Social Services	3,602		99,175	102,777		102,777	95,536	198,313			12
13	CNA Training											13
14	Program Transportation			4,664	4,664		4,664		4,664			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,234,847	541,412	1,445,805	5,222,064		5,222,064	753,401	5,975,465			16
	C. General Administration											
17	Administrative			660,000	660,000		660,000	(487,251)	172,749			17
18	Directors Fees											18
19	Professional Services			56,601	56,601	(15,048)	41,553	(1,124)	40,429			19
20	Dues, Fees, Subscriptions & Promotions			21,201	21,201		21,201	(7,766)	13,435			20
21	Clerical & General Office Expenses	27,310	38,962	553,618	619,890	(56,237)	563,653	(163,568)	400,085			21
22	Employee Benefits & Payroll Taxes			598,780	598,780	65,477	664,257		664,257			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,396	3,396		3,396		3,396			24
25	Other Admin. Staff Transportation							11,608	11,608			25
26	Insurance-Prop.Liab.Malpractice			305,334	305,334		305,334		305,334			26
27	Other (specify):*							64,211	64,211			27
28	**TOTAL General Administration**	27,310	38,962	2,198,930	2,265,202	(5,808)	2,259,394	(583,890)	1,675,504			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,403,621	1,285,874	4,172,698	9,862,193	(71,285)	9,790,908	340,224	10,131,132			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

St. Agnes Manor
0027870
Cost Report Reclassifications
01/01/13
12/31/13

Schedule V Line #			
22	Employee Benefits	65,477	
2	Food		65,477

To reclass cost of employee meals from raw food to employee benefits

+

Facility Name & ID Number St Agnes HC and Rehab Center #0027870 **Report Period Beginning:** 01/01/13 **Ending:** 12/31/13

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			70,208	70,208		70,208	33,325	103,533			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			9,902	9,902		9,902	123,188	133,090			32
33	Real Estate Taxes			294,972	294,972	15,048	310,020	33,257	343,277			33
34	Rent-Facility & Grounds			240,000	240,000		240,000	(240,000)				34
35	Rent-Equipment & Vehicles			7,164	7,164		7,164		7,164			35
36	Other (specify):*											36
37	TOTAL Ownership			622,246	622,246	15,048	637,294	(50,230)	587,064			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			1,161	1,161		1,161		1,161			38
39	Ancillary Service Centers	178,853		700,457	879,310		879,310	326,125	1,205,435			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			2,323	2,323		2,323		2,323			41
42	Provider Participation Fee			417,010	417,010		417,010		417,010			42
43	Other (specify):* Marketing					56,237	56,237	(56,237)				43
44	TOTAL Special Cost Centers	178,853		1,120,951	1,299,804	56,237	1,356,041	269,888	1,625,929			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,582,474	1,285,874	5,915,895	11,784,243		11,784,243	559,882	12,344,125			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number St Agnes HC and Rehab Center # 0027870 Report Period Beginning: 01/01/13 Ending: 12/31/13

VI. ADJUSTMENT DETAIL A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	29,399	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,234)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(47,828)	21		18
19	Entertainment	(292)	21		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(383,650)	21		24
25	Fund Raising, Advertising and Promotional	(8,064)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(641)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(156,726)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (569,036)		$	30

BHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(216,199)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (216,199)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (785,235)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

St Agnes HC and Rehab Center

ID# 0027870

Report Period Beginning: 01/01/13

Ending: 12/31/13

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Building Co-Management Fees	$ (72,000)	17	1
2	Building Co-Licenses & Fees	(1,720)	20	2
3	Building Co-Professional fees	(5,952)	19	3
4	Legal Fees	(10,639)	19	4
5	Bank Charges	(9,267)	21	5
6	Add'l R&M	10,154	06	6
7	Capitalized R&M	(7,506)	06	7
8	Outside Labor-Marketing Director	(56,237)	43	8
9	Interest expense offset	(3,559)	32	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(156,726)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number St Agnes HC and Rehab Center # 0027870 Report Period Beginning: 01/01/13 Ending: 12/31/13

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	111,387	0	0	0	0	0	0	0	111,387	1
2	Food Purchase	(1,234)	0	0	0	0	0	0	0	0	0	0	(1,234)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	3,695	0	0	0	0	0	0	0	0	3,695	5
6	Maintenance	2,648	0	2,574	51,643	0	0	0	0	0	0	0	56,865	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	1,414	0	6,269	163,030	0	0	0	0	0	0	0	170,713	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	624,522	0	0	0	0	0	0	0	624,522	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	33,343	0	0	0	0	0	0	0	33,343	11
12	Social Services	0	0	0	95,536	0	0	0	0	0	0	0	95,536	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	753,401	0	0	0	0	0	0	0	753,401	16
	C. General Administration													
17	Administrative	(72,000)	72,000	(487,251)	0	0	0	0	0	0	0	0	(487,251)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(16,591)	5,952	9,515	0	0	0	0	0	0	0	0	(1,124)	19
20	Fees, Subscriptions & Promotions	(9,784)	1,720	298	0	0	0	0	0	0	0	0	(7,766)	20
21	Clerical & General Office Expenses	(441,678)	0	175,549	102,561	0	0	0	0	0	0	0	(163,568)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	11,608	0	0	0	0	0	0	0	0	11,608	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	64,211	0	0	0	0	0	0	0	0	64,211	27
28	**TOTAL General Administration**	(540,053)	79,672	(226,070)	102,561	0	0	0	0	0	0	0	(583,890)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(538,639)	79,672	(219,801)	1,018,992	0	0	0	0	0	0	0	340,224	29

Facility Name & ID Number St Agnes HC and Rehab Center # 0027870 Report Period Beginning: 01/01/13 Ending: 12/31/13

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	29,399	0	3,926	0	0	0	0	0	0	0	0	33,325	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,559)	120,154	6,593	0	0	0	0	0	0	0	0	123,188	32
33	Real Estate Taxes	0	24,690	8,567	0	0	0	0	0	0	0	0	33,257	33
34	Rent-Facility & Grounds	0	(240,000)	0	0	0	0	0	0	0	0	0	(240,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	25,840	(95,156)	19,086	0	0	0	0	0	0	0	0	(50,230)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	326,125	0	0	0	0	0	0	0	326,125	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(56,237)	0	0	0	0	0	0	0	0	0	0	(56,237)	43
44	**TOTAL Special Cost Centers**	(56,237)	0	0	326,125	0	0	0	0	0	0	0	269,888	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(569,036)	(15,484)	(200,715)	1,345,117	0	0	0	0	0	0	0	559,882	45

Facility Name & ID Number St Agnes HC and Rehab Center # 0027870 Report Period Beginning: 01/01/13 Ending: 12/31/13

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Peter O'Brien	100	ST MARTHA MANOR	CHICAGO	1721 CORP	CHICAGO	BUILDING CO
		MARGARET MANOR, INC.	CHICAGO	WINDY CITY NURSI	CHICAGO	OUTSIDE LABOR
		MARGARET MANOR NORTH	CHICAGO	WINDY CITY NURSI	CHICAGO	NURSING, DIETAI
		SACRED HEART HOME	CHICAGO	MADO MANAGEME	CHICAGO	BOOKEEPING/MG

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	$ 240,000	1721 Corp	100.00%	$	$ (240,000)	1
2	V	32	Interest Expense		1721 Corp	100.00%	120,154	120,154	2
3	V	33	Real Estate Taxes		1721 Corp	100.00%	24,690	24,690	3
4	V	17	Management Fees		1721 Corp	100.00%	72,000	72,000	4
5	V	20	Licenses & Fees		1721 Corp	100.00%	1,720	1,720	5
6	V	19	Professional Fees		1721 Corp	100.00%	5,952	5,952	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 240,000			$ 224,516	$ * (15,484)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number St Agnes HC and Rehab Center # 0027870 Report Period Beginning: 01/01/13 Ending: 12/31/13

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	MADO MGMT. LP	100.00%	$ 3,695	$ 3,695	15
16	V	6	REPAIRS AND MAINT.		MADO MGMT. LP	100.00%	2,574	2,574	16
17	V	17	ADMINISTRATIVE		MADO MGMT. LP	100.00%			17
18	V	19	PROFESSIONAL FEES		MADO MGMT. LP	100.00%	9,515	9,515	18
19	V	20	DUES AND SUBSCRIPTIONS		MADO MGMT. LP	100.00%	298	298	19
20	V	21	CLERICAL AND GENERAL		MADO MGMT. LP	100.00%	175,549	175,549	20
21	V	25	AUTO EXPENSE		MADO MGMT. LP	100.00%	11,608	11,608	21
22	V	26	PROPERTY INSURANCE		MADO MGMT. LP	100.00%			22
23	V	27	GEN. ADMIN. - EMP. BEN.		MADO MGMT. LP	100.00%	34,092	34,092	23
24	V	30	DEPRECIATION		MADO MGMT. LP	100.00%	3,926	3,926	24
25	V	32	INTEREST		MADO MGMT. LP	100.00%	6,593	6,593	25
26	V	33	REAL ESTATE TAXES		MADO MGMT. LP	100.00%	4,283	4,283	26
27	V								27
28	V	17	MANAGEMENT FEES	660,000	MADO MGMT. LP	100.00%		(660,000)	28
29	V								29
30	V	17	SALARY-P. O'BRIEN		MADO MGMT. LP	100.00%	44,550	44,550	30
31	V	27	EMP. BEN - O'BRIEN		MADO MGMT. LP	100.00%	5,720	5,720	31
32	V								32
33	V								33
34	V	17	ADMINISTRATIVE SALARY		MADO MGMT. LP	100.00%	128,199	128,199	34
35	V	27	GEN. ADMIN. - EMP. BEN.		MADO MGMT. LP	100.00%	24,399	24,399	35
36	V	33	REAL ESTATE TAXES		MADO MGMT. LP	100.00%	4,284	4,284	36
37	V								37
38	V								38
39	Total			$ 660,000			$ 459,285	$ * (200,715)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number St Agnes HC and Rehab Center # 0027870 Report Period Beginning: 01/01/13 Ending: 12/31/13

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	NURSING	$	WINDY CITY NURSING	100.00%	$	$ 624,522	15
16	V	39	THERAPY		WINDY CITY NURSING	100.00%		326,125	16
17	V	01	DIETARY		WINDY CITY NURSING	100.00%		111,387	17
18	V	11	ACTIVITY		WINDY CITY NURSING	100.00%		33,343	18
19	V	21	CLERICAL		WINDY CITY NURSING	100.00%		102,561	19
20	V	06	MAINTENANCE		WINDY CITY NURSING	100.00%		51,643	20
21	V	12	SOCIAL SERVICES		WINDY CITY NURSING	100.00%		95,536	21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ * 1,345,117	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number St Agnes HC and Rehab Center # 0027870 Report Period Beginning: 01/01/13 Ending: 12/31/13

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	PETER O'BRIEN	100	ST. MARTHA MANOR	CHICAGO	1721 CORP	CHICAGO	BUILDING CO	1
2			MARGARET MANOR, INC.	CHICAGO	WINDY CITY NURSI	CHICAGO	OUTSIDE LABOR	2
3			MARGARET MANOR NORTH	CHICAGO	WINDY CITY NURSI	CHICAGO	NURSING, DIETAI	3
4			SACRED HEART HOME	CHICAGO	MADO MANAGEME	CHICAGO	BOOKEEPING/MG	4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number St Agnes HC and Rehab Center # 0027870 Report Period Beginning: 01/01/13 Ending: 12/31/13

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Peter O'Brien	Owner	Administrative	100.00	See Attached	11.4	24.75	Alloc. Salary	$ 44,550	17-7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 44,550		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Peter O'Brien
Weighted Average Hours Worked
And Compensation
1/1/13 - 12/31/13

Facility Name	% Allocation	Average Hours Worked	Allocated Salary from MADO Mgmt	Total Compensation
Margaret Manor	17.72%	8.2	$ 31,896	$ 31,896
Margaret Manor North	14.75%	6.8	$ 26,550	26,550
St. Agnes	24.75%	11.4	$ 44,550	44,550
Sacred Heart	22.92%	10.5	$ 41,256	41,256
St. Martha	19.86%	9.1	$ 35,748	35,748
Other	-	14.0	-	-
Total	100.00%	60.0	$ 180,000	$ 180,000

Facility Name & ID Number St Agnes HC and Rehab Center # 0027870 Report Period Beginning: 01/01/13 Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number St Agnes HC and Rehab Center # 0027870 Report Period Beginning: 01/01/13 Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: MADO MGMT LP
Street Address: 1541 N. WELLS ST
City / State / Zip Code: CHICAGO, IL 60610
Phone Number: (312) 787-9400
Fax Number: (312) 787-9434

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	226,409	5	$ 14,929	$	56,032	$ 3,695	1
2	6	REPAIRS AND MAINT.	PATIENT DAYS	226,409	5	10,399		56,032	2,574	2
3	17	ADMINISTRATIVE	PATIENT DAYS	226,409	5			56,032		3
4	19	PROFESSIONAL FEES	PATIENT DAYS	226,409	5	38,446		56,032	9,515	4
5	20	DUES AND SUBSCRIPTIONS	PATIENT DAYS	226,409	5	1,203		56,032	298	5
6	21	CLERICAL AND GENERAL	PATIENT DAYS	226,409	5	709,342		56,032	175,549	6
7	25	AUTO EXPENSE	PATIENT DAYS	226,409	5	46,904		56,032	11,608	7
8	26	PROPERTY INSURANCE	PATIENT DAYS	226,409	5			56,032		8
9	27	GEN. ADMIN. - EMP. BEN.	PATIENT DAYS	226,409	5	137,755		56,032	34,092	9
10	30	DEPRECIATION	PATIENT DAYS	226,409	5	15,864		56,032	3,926	10
11	32	INTEREST	PATIENT DAYS	226,409	5	26,640		56,032	6,593	11
12	33	REAL ESTATE TAXES	PATIENT DAYS	226,409	5	17,306		56,032	4,283	12
13										13
14										14
15										15
16	17	SALARY - P. O'BRIEN	AVG. HOURS WORKED	60	5	180,000	180,000	11	44,550	16
17	27	EMP. BEN- P. O'BRIEN	AVG. HOURS WORKED	60	5	30,107		11	5,720	17
18										18
19										19
20	17	ADMINISTRATIVE SALARY	DIRECT ALLOCATION		5	128,200	128,200		128,200	20
21	27	GEN. ADMIN. - EMP. BEN.	DIRECT ALLOCATION		5	24,399			24,399	21
22	33	REAL ESTATE TAXES	DIRECT ALLOCATION		1	4,284			4,284	22
23										23
24										24
25	TOTALS					$ 1,385,777	$ 308,200		$ 459,286	25

Facility Name & ID Number St Agnes HC and Rehab Center # 0027870 Report Period Beginning: 01/01/13 Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

Name of Related Organization	Windy City Nursing
Street Address	1541 N. Wells Street
City / State / Zip Code	Chicago, IL 60610
Phone Number	(312) 787-9400
Fax Number	(312) 787-9434

B. Show the allocation of costs below. If necessary, please attach worksheets.

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	NURSING	DIRECT ALLOCATION			$	$		$ 624,522	1
2	39	THERAPY	DIRECT ALLOCATION						326,125	2
3	1	DIETARY	DIRECT ALLOCATION						111,387	3
4	11	ACTIVITY	DIRECT ALLOCATION						33,343	4
5	21	CLERICAL	DIRECT ALLOCATION						102,561	5
6	6	MAINTENANCE	DIRECT ALLOCATION						51,643	6
7	12	SOCIAL SERVICES	DIRECT ALLOCATION						95,536	7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 1,345,117	25

Facility Name & ID Number St Agnes HC and Rehab Center # 0027870 Report Period Beginning: 01/01/13 Ending: 12/31/13

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	Note Payable-Bridgeview Bank		X	Working Capital				400,000			5,510	6
7	Allocated by related entity	X									833	7
8	Allcoated from MADO Mgmt	X									6,593	8
9	TOTAL Facility Related						$	$ 400,000			$ 12,936	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$ 400,000			$ 12,936	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number St Agnes HC and Rehab Center # 0027870 Report Period Beginning: 01/01/13 Ending: 12/31/13

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

Line			
1. Real Estate Tax accrual used on 2012 report.	$	238,498	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	262,423	2
3. Under or (over) accrual (line 2 minus line 1).	$	23,925	3
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)	$	271,046	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	15,048	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $** ______ **For** ______ **Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	310,019	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:

Year	Amount	Line
2008	187,700	8
2009	214,647	9
2010	223,992	10
2011	223,060	11
2012	234,213	12

2013 Accrual = $ 234,213 * 1.16 = $271,046
Allocated from MADO mgmt = $4,284
Beginning Accrual Adjusted

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2012	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME St Agnes HC and Rehab Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0027870

CONTACT PERSON REGARDING THIS REPORT Peter O'Brien

TELEPHONE (312) 787-9400 FAX #: (312) 787-9434

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2012 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2012.

	(A)	(B)	(C)	(D)
	Tax Index Number	**Property Description**	**Total Tax**	**Tax Applicable to Nursing Home**
1.	17-22-301-014-0000	Long Term Care Property	$ 13,066.39	$ 13,066.39
2.	17-22-301-015-0000	Long Term Care Property	$ 32,104.02	$ 32,104.02
3.	17-22-301-016-0000	Long Term Care Property	$ 128,681.06	$ 128,681.06
4.	17-22-301-017-0000	Long Term Care Property	$ 65,159.57	$ 65,159.57
5.	17-22-301-050-0000	Long Term Care Property	$ 19,127.88	$ 19,127.88
6.	17-04-204-012-0000	Home Office Allocation	$ 25,450.00	$ 4,283.72
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 283,588.92	$ 262,422.64

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES ___ NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

MADO MANAGEMENT L.P.
Allocation of 2012 Real Estate Tax
For the Year Ended
12/31/2013

PROPERTY ADDRESS	
1541 N. Wells	$ 25,450.20
(Main Office)	0.68
17-04-204-012-0000	$ 17,306.14

Homes	**Basis of Allocation (2013 Patient Days)**	**% Allocation**	**Real Estate Tax Allocation**
Margaret Manor, Inc. IDPH#0011239	$ 40,115	17.72%	$ 3,067
Margaret Manor North IDPH #0017178	$ 33,406	14.76%	$ 2,554
St. Agnes Manor, Inc. IDPH#0027870	$ 56,032	24.75%	$ 4,284
Sacred Heart Home IDPH#0013334	$ 51,859	22.91%	$ 3,965
St. Martha Manor IDPHA#0023770	$ 44,956	19.86%	$ 3,437
TOTAL	**$ 226,368**	**100%**	**$ 17,306**

Facility Name & ID Number St Agnes HC and Rehab Center # 0027870 Report Period Beginning: 01/01/13 Ending: 12/31/13

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 68,975 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	31,879	1983	$ 72,250	1
2					2
3	TOTALS	31,879		$ 72,250	3

Facility Name & ID Number St Agnes HC and Rehab Center # 0027870 Report Period Beginning: 01/01/13 Ending: 12/31/13

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4				1983	$ 424,750	$	35	$	$	$ 424,750	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1983	1,400,995		20			1,333,294	9
10	Various			1984	132,601		20			132,601	10
11	Various			1986	21,150		20			21,150	11
12	Various			1987	10,000		20			10,000	12
13	Various			1989	72,045		20			63,352	13
14	Various			1990	150,700		20	360	360	133,156	14
15	Various			1991	37,665		20			34,389	15
16	Various			1992	45,688		20	7	7	36,608	16
17	Various			1993	56,127		20	2,806	2,806	52,657	17
18	Various			1994	133,605		20	6,680	6,680	123,313	18
19	Various			1995	110,000		20	(24,873)	(24,873)	110,000	19
20	Various			1996	173,235		20	9,125	9,125	158,712	20
21	Various			1997	219,118		20	11,582	11,582	190,885	21
22	Various			1998	314,520		20	15,687	15,687	244,015	22
23	Various			1999	387,533		20	19,377	19,377	271,283	23
24	Various			2000	69,634		20	3,482	3,482	45,556	24
25	Various			2001	107,788		20	5,389	5,389	68,086	25
26	Various			2002	44,685		20	1,990	1,990	33,133	26
27	Various			2003	12,389		20	846	846	10,738	27
28	Various			2004	50,665		20	4,923	4,923	46,326	28
29	Various			2005	57,918		20	3,029	3,029	27,301	29
30	Various			2006	25,274		20	2,634	2,634	19,821	30
31	Various			2007	35,883		20	3,221	3,221	20,717	31
32	Various			2008	56,272		20	2,814	2,814	15,215	32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number St Agnes HC and Rehab Center # 0027870 Report Period Beginning: 01/01/13 Ending: 12/31/13

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 4,150,240	$		$ 69,079	$ 69,079	$ 3,627,058	1
2	Elevator - New Motor Drive	2009	4,287		20	214	214	1,071	2
3	Generator - Monitoring Meter	2009	2,758		20	138	138	632	3
4	Disconnect, Repair, & Reinstall Fire Pressure Pump	2009	5,130		20	257	257	1,198	4
5	Upgrade Cpu/Software In Elevator	2009	4,136		20	207	207	965	5
6	Fire Sprinkler Repairs From Pipe Breaking	2009	6,384		20	319	319	1,596	6
7	New Water Heater	2010	5,225		20	261	261	805	7
8	Centralize A/C System In Annex Building	2010	8,215		20	411	411	1,472	8
9	Exhaust Assembly	2010	5,285		20	264	264	925	9
10	Repair Fire Sprinkler System	2010	2,725		20	136	136	477	10
11	Grinding & Tuckpointing - East & Southwest Walls	2010	6,700		20	335	335	1,173	11
12	Replaced Smoke Detectors & Fire Alarm System	2011	6,261		20	313	313	939	12
13	12 1/2 Ton Cooling 224,000 Btu Gas Heating Unit	2011	15,965		20	798	798	2,261	13
14	New Car Top Selector On Elevator	2011	4,160		20	208	208	572	14
15	Remodel 3Rd Floor-Tile, Counters, Sinks, Cabinets, Walls, Paintin	2011	19,859		20	993	993	2,400	15
16	Repair 3 A/C Units In The Courtyard, Alley And Rooftop	2011	3,355		20	168	168	434	16
17	Fire Sprinkler Upgrades	2012	8,540		20	427	427	783	17
18	Three 25-Ton Evaporative Condenser Units	2012	72,660		20	3,633	3,633	6,055	18
19	Smoke Detector Replacements For The Fire Alarm System	2012	5,500		20	275	275	458	19
20	Repair East & West Compressor	2012	7,960		20	398	398	796	20
21	Heat & Smoke Detector	2013	3,713		20	186	186	186	21
22	Sprinkler Heads	2013	2,518		20	94	94	94	22
23	Light Fixtures	2013	4,989			42	42	42	23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32	Financial statement deprciation(vehicle depreciation included on pg13)			68,433			(68,433)		32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,356,565	$ 68,433		$ 79,156	$ 10,723	$ 3,652,392	34

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number St Agnes HC and Rehab Center # 0027870 Report Period Beginning: 01/01/13 Ending: 12/31/13

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 4,356,565	$ 68,433		$ 79,156	$ 10,723	$ 3,652,392	1
2	Related Party Transactions								2
3	Building:								3
4	Allocated from MADO Management	1988	51,300	1,873	20	1,466	(49,834)	26,383	4
5									5
6									6
7									7
8									8
9									9
10	Leasehold Improvements:	1995	1,190		20	60	(1,130)	1,101	10
11	Allocated from MADO Management	1993	19,540	520	20	977	(18,563)	19,955	11
12	Allocated from MADO Management	2000	2,922		20	146	(2,776)	1,976	12
13	Allocated from MADO Management	2001	1,266		20	63	(1,203)	805	13
14	Allocated from MADO Management	2002	1,991		20	96	(1,895)	1,941	14
15	Allocated from MADO Management	2004	560	6	20	28	(532)	260	15
16	Allocated from MADO Management								16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,435,334	$ 70,832		$ 81,992	$ (65,210)	$ 3,704,813	34

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number St Agnes HC and Rehab Center # 0027870 Report Period Beginning: 01/01/13 Ending: 12/31/13

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 163,660	$	$ 8,950	$ 8,950	10	$ 130,954	71
72	Current Year Purchases	3,278		328	328	10	328	72
73	Fully Depreciated Assets	196,930					196,930	73
74								74
75	TOTALS	$ 363,868	$	$ 9,278	$ 9,278		$ 328,212	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		2009 NISSAN MURANO	2008	$ 33,984	$ 1,775	$ 6,797	$ 5,022	5	$ 23,935	76
77		Allocated from MADO Managem	2012	50,903	1,978	5,918	3,940	5	49,394	77
78										78
79										79
80	TOTALS			$ 84,887	$ 3,753	$ 12,715	$ 8,962		$ 73,329	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,956,339	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 74,585	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 103,984	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 29,399	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,106,354	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number St Agnes HC and Rehab Center # 0027870 Report Period Beginning: 01/01/13 Ending: 12/31/13

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2014	$
13.	/2015	$
14.	/2016	$

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO
16. Rental Amount for movable equipment: $ 7,164 Description: Ice Machine - $1491, Vending Machine - $678, Copier - $4196, Postage Machine $799
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number St Agnes HC and Rehab Center # 0027870 Report Period Beginning: 01/01/13 Ending: 12/31/13

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

[ ] YES
[X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
COMMUNITY COLLEGE [ ]
HOURS PER CNA ____

3. CLINICAL PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-01	hrs	$		$ 192,147	$		$ 192,147	1
2	Licensed Speech and Language Development Therapist	39-01	hrs			166,942			166,942	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-01	hrs	75,689		191,395			267,084	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-02	# of prescrpts				315,518		315,518	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Radiology, Lab, Beds	39-02					58,814		58,814	12
13	Other (specify): RT			178,853		326,125			504,978	13
14	TOTAL			$ 254,542		$ 876,609	$ 374,332		$ 1,505,483	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number St Agnes HC and Rehab Center # 0027870 Report Period Beginning: 01/01/13 Ending: 12/31/13

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/13 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 77,605	$ 77,614	1
2	Cash-Patient Deposits	659	659	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	2,274,049	2,274,049	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	950	950	6
7	Other Prepaid Expenses	2,700	2,700	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Supplemental Schedule	126,888	144,827	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,482,851	$ 2,500,799	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		75,250	13
14	Buildings, at Historical Cost		1,740,933	14
15	Leasehold Improvements, at Historical Cost	1,957,557	1,964,851	15
16	Equipment, at Historical Cost	348,659	1,302,192	16
17	Accumulated Depreciation (book methods)	(1,313,051)	(4,014,809)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	2,004	79,461	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(48,587)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Supplemental Schedule		2,798,303	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 995,169	$ 3,897,594	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,478,020	$ 6,398,393	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 2,535,350	$ 2,558,733	26
27	Officer's Accounts Payable	2,089,924	2,089,924	27
28	Accounts Payable-Patient Deposits	7,685	7,685	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	26,378	26,378	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	271,046	271,046	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	St. Agnes Med Equipment Co	315,757	315,757	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 5,246,140	$ 5,269,523	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		4,004,262	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Supplemental Schedule	3,669,427	3,003,860	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 3,669,427	$ 7,008,122	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 8,915,567	$ 12,277,645	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (5,437,547)	$ (5,879,252)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,478,020	$ 6,398,393	48

*(See instructions.)

STATE OF ILLINOIS

Facility Name & ID Number **St Agnes HC and Rehab #** **0027870** **Report Period Beginning:** **01/01/13** **Ending:** **12/31/13**

Supplmetnal Schedule of Other Assets and Liabilities

	Other Current Assets	Amount		Other Current Liabilities	Amount
09A	Ex Account	105,407			
09B	Due from Employees	763			
09C	Refund Account	20,719			
09D	Loan Cost	17,939			
		144,828			0

	Other Non-Current Assets	Amount		Other Non-Current Liabilities	Amount
23A	Due to/From MADO	1,298,303	43A	940 Cullom	(256,000)
23B	Misc Cash To/From Borrowe	1,500,000	43B	Margaret Manor of IL	(54,000)
			43C	St. Marthas	(1,093,000)
			43D	Mado Mgmt	(255,019)
			43E	Sacred Heart	180,000
			43F	Due To/From Complex	50,000
			43G	Exchange Check	(68)
			43H	Due to/From Sirloin	(375)
			43I	Due To/From OBM	(28,038)
			43J	Due to From DOB Sr	(1,047,360)
			43K	Note Payable-Signature Bank	(100,000)
			43L	Note Payable-Bridgeview	(400,000)
			43M		
			43N		
		2,798,303			(3,003,860)

Facility Name & ID Number St Agnes HC and Rehab Center # 0027870 Report Period Beginning: 01/01/13 Ending: 12/31/13

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (4,888,775)	1
2	Restatements (describe):		2
3	equity adj	(93,938)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (4,982,713)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(454,834)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (454,834)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (5,437,547)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number St Agnes HC and Rehab Center # 0027870 Report Period Beginning: 01/01/13 Ending: 12/31/13

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 10,748,824	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 10,748,824	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	236,162	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 236,162	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	(151)	12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	2,256	17
18	Sale of Supplies to Non-Patients	46	18
19	Laboratory	277	19
20	Radiology and X-Ray	(61)	20
21	Other Medical Services	5,061	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 7,428	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)	(10,689)	27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ (10,689)	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,981,725	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,374,927	31
32	Health Care	5,757,501	32
33	General Administration	1,917,518	33
	B. Capital Expense		
34	Ownership	622,246	34
	C. Ancillary Expense		
35	Special Cost Centers	347,357	35
36	Provider Participation Fee	417,010	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 11,436,559	40
41	**Income before Income Taxes (line 30 minus line 40)****	(454,834)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (454,834)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 8,248,040	44
45	Private Pay - Net Inpatient Revenue	212,198	45
46	Medicare - Net Inpatient Revenue	2,337,290	46
47	Other-(specify) Prior Yr adj	(48,704)	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 10,748,824	49

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? ____________ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number St Agnes HC and Rehab Center # 0027870 Report Period Beginning: 01/01/13 Ending: 12/31/13

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing			$	$	1
2	Assistant Director of Nursing	10	10	337	33.70	2
3	Registered Nurses	13,770	13,984	394,830	28.23	3
4	Licensed Practical Nurses	35,955	37,292	981,642	26.32	4
5	CNAs & Orderlies	131,933	140,813	1,597,950	11.35	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	13,278	13,987	254,542	18.20	8
9	Activity Director	4,234	4,681	59,654	12.74	9
10	Activity Assistants	9,919	10,370	106,572	10.28	10
11	Social Service Workers	436	436	3,602	8.26	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	34,968	38,681	418,386	10.82	15
16	Dishwashers	489	511	4,260	8.34	16
17	Maintenance Workers	14,509	16,060	169,721	10.57	17
18	Housekeepers	27,307	29,559	289,100	9.78	18
19	Laundry	17,140	18,863	190,347	10.09	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,295	2,512	27,310	10.87	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,138	1,171	14,571	12.44	31
32	Other Health Care(specify)					32
33	Other(specify) Security	6,553	7,034	69,650	9.90	33
34	TOTAL (lines 1 - 33)	313,934	335,964	$ 4,582,474 *	$ 13.64	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	11	$ 627	01-03	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	392	18,765	10-03	38
39	Pharmacist Consultant	29	4,770	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	25	1,213	11.03	44
45	Social Service Consultant	4,056	99,176	12-03	45
46	Other(specify) Outside Labor Maint	2,082	51,643	06-03	46
47	Outside Labor Dietary	4,200	111,387	01-03	47
48	Outside Labor Activities	2,073	33,343	11-03	48
49	TOTAL (lines 35 - 48)	12,868	$ 320,924		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	5,483	$ 198,435	10-03	50
51	Licensed Practical Nurses	16,386	534,762	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	21,869	$ 733,197		53

Facility Name & ID Number St Agnes HC and Rehab Center # 0027870 Report Period Beginning: 01/01/13 Ending: 12/31/13

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			$
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$

B. Administrative - Other

Description	Amount
MADO Management	$ 660,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 660,000

C. Professional Services

Vendor/Payee	Type	Amount
Intertek Testing Services	Consultant	$ 5,970
Wolf & Company, LLP	Accounting	8,053
Personnel Planners	Unemployment Consult	3,520
Life Safety Resources	Vertical Shaft Consult	3,826
Frost, Ruttenberg & Rothblatt	Accounting	9,250
Scientific Control Lab	Engineering Consultant	295
Neal, Gerber&Eisenberg	Legal	3,627
Shefsky&froelich	Legal	5,961
Alice D. Borzym	Legal	1,050
Non deductible fees	Legal	15,048
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 56,600

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 96,740
Unemployment Compensation Insurance	135,380
FICA Taxes	349,410
Employee Health Insurance	10,735
Employee Meals	65,477
Illinois Municipal Retirement Fund (IMRF)*	
401-K Employers	128
Other Employee Welfare	6,387
TOTAL (agree to Schedule V, line 22, col.8)	$ 664,257

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	8,184
Health Care Worker Background Check (Indicate # of checks performed 80)	2,400
Patient Background Checks 229	3,290
Licenses, Dues & Fees	7,328
Allocated from MADO Mgmt	1,720
Less: Public Relations Expense	( )
Non-allowable advertising	(8,064)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 14,858

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	836
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 836

**See instructions.

Facility Name & ID Number St Agnes HC and Rehab Center # 0027870 Report Period Beginning: 01/01/13 Ending: 12/31/13

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
					Amount of Expense Amortized Per Year								
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number **St Agnes HC and Rehab Center** # **0027870** Report Period Beginning: **01/01/13** Ending: **12/31/13**

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **n/a**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **n/a**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **48,872** Line **10-02**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? ____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES ____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **417,010**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **65,477** Has any meal income been offset against related costs? **No** Indicate the amount. $ **n/a**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100% Ln 1**
d. Have vehicle usage logs been maintained? **yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/a**
g. Does the facility transport residents to and from day training? **No**
Indicate the amount of income earned from providing such transportation during this reporting period. $ **No**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.