FOR BHF USE

LL1

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.

2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

I. IDPH License ID Number: 0017178

Facility Name: Margaret Manor North Branch

Address: 940 West Cullom Ave (Number) Chicago (City) 60613 (Zip Code)

County: Cook

Telephone Number: 773 525-9000 **Fax #** 773 525-8016

HFS ID Number:

Date of Initial License for Current Owners: 00/00/69

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	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 1/1/14 to 12/31/14 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) CAMILLE B. LOCKHART, PARTNER
(Firm Name & Address) BKD, LLP, P. O. BOX 1190, SPRINGFIELD, MO 65801-1190
(Telephone) (417) 865-8701 Fax # (417) 865-0682

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 Margaret Manor North Branch # 0017178 Report Period Beginning: 1/1/14 Ending: 12/31/14

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 _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	99	Intermediate (ICF)	99	36,135	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	99	TOTALS	99	36,135	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	32,711	427	64	33,202	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	32,711	427	64	33,202	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.88%

D. How many bed-hold days during this year were paid by the Department?
0 (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 1969

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

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

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/14 Fiscal Year: 12/31/14

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

Facility Name & ID Number Margaret Manor North Branch # 0017178 **Report Period Beginning:** 1/1/14 **Ending:** 12/31/14

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

	Operating Expenses	Costs Per General Ledger: Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	179,380	19,879	11,600	210,859		210,859		210,859			1
2	Food Purchase		358,735		358,735	(43,048)	315,687		315,687			2
3	Housekeeping	90,747	78,338		169,085		169,085		169,085			3
4	Laundry	38,109	7,633		45,742		45,742		45,742			4
5	Heat and Other Utilities			80,248	80,248		80,248	759	81,007			5
6	Maintenance	59,372		70,595	129,967		129,967	1,368	131,335			6
7	Other (specify):*	116,175			116,175		116,175		116,175			7
8	**TOTAL General Services**	483,783	464,585	162,443	1,110,811	(43,048)	1,067,763	2,127	1,069,890			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	515,326	37,856	162,304	715,486		715,486		715,486			10
10a	Therapy											10a
11	Activities	87,244	11,392	91,114	189,750		189,750		189,750			11
12	Social Services	78,401		140,417	218,818		218,818		218,818			12
13	CNA Training											13
14	Program Transportation			1,261	1,261		1,261		1,261			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	680,971	49,248	401,096	1,131,315		1,131,315		1,131,315			16
	C. General Administration											
17	Administrative			395,000	395,000		395,000	(307,905)	87,095			17
18	Directors Fees											18
19	Professional Services			22,016	22,016		22,016	6,252	28,268			19
20	Dues, Fees, Subscriptions & Promotions			19,674	19,674		19,674	(1,191)	18,483			20
21	Clerical & General Office Expenses	5,462	23,108	50,495	79,065		79,065	156,334	235,399			21
22	Employee Benefits & Payroll Taxes			193,256	193,256	43,048	236,304	(6,340)	229,964			22
23	Inservice Training & Education											23
24	Travel and Seminar			400	400		400		400			24
25	Other Admin. Staff Transportation							2,356	2,356			25
26	Insurance-Prop.Liab.Malpractice			129,866	129,866		129,866	3,621	133,487			26
27	Other (specify):*							28,339	28,339			27
28	**TOTAL General Administration**	5,462	23,108	810,707	839,277	43,048	882,325	(118,534)	763,791			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,170,216	536,941	1,374,246	3,081,403		3,081,403	(116,407)	2,964,996			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.

Facility Name & ID Number Margaret Manor North Branch #0017178 Report Period Beginning: 1/1/14 Ending: 12/31/14

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			23,488	23,488		23,488	20,655	44,143			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			40,025	40,025		40,025	109,749	149,774			32
33	Real Estate Taxes							99,674	99,674			33
34	Rent-Facility & Grounds			210,000	210,000		210,000	(210,000)				34
35	Rent-Equipment & Vehicles			2,905	2,905		2,905		2,905			35
36	Other (specify):*											36
37	**TOTAL Ownership**			276,418	276,418		276,418	20,078	296,496			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops			1,130	1,130		1,130		1,130			40
41	Coffee and Gift Shops		5,163		5,163		5,163	(4,605)	558			41
42	Provider Participation Fee											42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		5,163	1,130	6,293		6,293	(4,605)	1,688			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,170,216	542,104	1,651,794	3,364,114		3,364,114	(100,934)	3,263,180			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 Margaret Manor North Branch # 0017178 Report Period Beginning: 1/1/14 Ending: 12/31/14

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 Refer-ence	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				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				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	10,327	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance	(6,340)	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(1,720)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(688)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	15,264			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 16,843		$	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)	(117,777)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (117,777)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (100,934)		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 **Page 5A**

Margaret Manor North Branch

ID# **0017178**

Report Period Beginning: **1/1/14**

Ending: **12/31/14**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	VENDING INCOME	$ (4,605)	41	1
2	BANK CHARGES	(1,174)	21	2
3	MISC INCOME	(33)	21	3
4	ADJ TO S/L DEPR	16,060	30	4
5	RE TAX ADJUSTMENT	5,016	33	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
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**	15,264		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Margaret Manor North Branch # 0017178 **Report Period Beginning:** 1/1/14 **Ending:** 12/31/14

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	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	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	759	0	0	0	0	0	0	0	0	759	5
6	Maintenance	0	0	1,368	0	0	0	0	0	0	0	0	1,368	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	2,127	0	0	0	0	0	0	0	0	2,127	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	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	(307,905)	0	0	0	0	0	0	0	0	(307,905)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	6,252	0	0	0	0	0	0	0	0	6,252	19
20	Fees, Subscriptions & Promotions	(1,720)	0	529	0	0	0	0	0	0	0	0	(1,191)	20
21	Clerical & General Office Expenses	8,432	0	147,902	0	0	0	0	0	0	0	0	156,334	21
22	Employee Benefits & Payroll Taxes	(6,340)	0	0	0	0	0	0	0	0	0	0	(6,340)	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	2,356	0	0	0	0	0	0	0	0	2,356	25
26	Insurance-Prop.Liab.Malpractice	0	0	3,621	0	0	0	0	0	0	0	0	3,621	26
27	Other (specify):*	0	0	28,339	0	0	0	0	0	0	0	0	28,339	27
28	**TOTAL General Administration**	372	0	(118,906)	0	0	0	0	0	0	0	0	(118,534)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	372	0	(116,779)	0	0	0	0	0	0	0	0	(116,407)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Margaret Manor North Branch # 0017178 **Report Period Beginning:** 1/1/14 **Ending:** 12/31/14

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	16,060	0	4,595	0	0	0	0	0	0	0	0	20,655	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	104,736	5,013	0	0	0	0	0	0	0	0	109,749	32
33	Real Estate Taxes	5,016	91,855	2,803	0	0	0	0	0	0	0	0	99,674	33
34	Rent-Facility & Grounds	0	(210,000)	0	0	0	0	0	0	0	0	0	(210,000)	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	21,076	(13,409)	12,411	0	0	0	0	0	0	0	0	20,078	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	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	(4,605)	0	0	0	0	0	0	0	0	0	0	(4,605)	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	(4,605)	0	0	0	0	0	0	0	0	0	0	(4,605)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	16,843	(13,409)	(104,368)	0	0	0	0	0	0	0	0	(100,934)	45

Facility Name & ID Number Margaret Manor North Branch # 0017178 Report Period Beginning: 1/1/14 Ending: 12/31/14

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	MARGARET MANOR, INC.	CHICAGO	Long Term Care LP	CHICAGO	REAL ESTATE
		ST. MARTHA'S MANOR	CHICAGO	Windy City Nursing	CHICAGO	OUTSIDE LABOR
		SACRED HEART HOME	CHICAGO			FOR: NURSING &
						DIETARY
				Mado Management	CHICAGO	BOOKKEEPING/M

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	$ 210,000	940 W. Cullom	100.00%	$	$ (210,000)	1
2	V	32	Interest		940 W. Cullom	100.00%	104,736	104,736	2
3	V	33	Real Estate Tax		940 W. Cullom	100.00%	91,855	91,855	3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 210,000			$ 196,591	$ * (13,409)	14

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

Facility Name & ID Number Margaret Manor North Branch # 0017178 Report Period Beginning: 1/1/14 Ending: 12/31/14

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 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)	
15	V	5	Utilities	$	Mado Management	100.00%	$ 759	$ 759	15
16	V	6	Repairs & Maintenance		Mado Management	100.00%	1,368	1,368	16
17	V	19	Professional Fees		Mado Management	100.00%	6,252	6,252	17
18	V	20	Dues and Subscriptions		Mado Management	100.00%	529	529	18
19	V	21	Clerical and General		Mado Management	100.00%	147,902	147,902	19
20	V	25	Auto Expense		Mado Management	100.00%	2,356	2,356	20
21	V	26	Insurance		Mado Management	100.00%	3,621	3,621	21
22	V	27	Employee Benefits		Mado Management	100.00%	20,260	20,260	22
23	V	30	Depreciation		Mado Management	100.00%	4,595	4,595	23
24	V	32	Interest		Mado Management	100.00%	5,013	5,013	24
25	V	33	Real Estate Taxes		Mado Management	100.00%	2,803	2,803	25
26	V								26
27	V	17	Management Fees	395,000	Mado Management	100.00%		(395,000)	27
28	V								28
29	V	17	Salary - P. O'Brien		Mado Management	100.00%	28,782	28,782	29
30	V	27	Employee Benefits		Mado Management	100.00%	2,849	2,849	30
31	V								31
32	V	17	Administrative Salary		Mado Management	100.00%	58,313	58,313	32
33	V	27	Employee Benefits		Mado Management	100.00%	5,230	5,230	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 395,000			$ 290,632	$ * (104,368)	39

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

Facility Name & ID Number Margaret Manor North Branch # 0017178 Report Period Beginning: 1/1/14 Ending: 12/31/14

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 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)	
15	V	01	DIETARY	$ 7,793	WINDY CITY NURSING	100.00%	$ 7,793	$	15
16	V	10	NURSING	158,583	WINDY CITY NURSING	100.00%	158,583		16
17	V	12	SOCIAL SERVICE	131,101	WINDY CITY NURSING	100.00%	131,101		17
18	V	21	ADMINISTRATIVE CLERICAL	43,878	WINDY CITY NURSING	100.00%	43,878		18
19	V	11	ACTIVITIES	62,545	WINDY CITY NURSING	100.00%	62,545		19
20	V								20
21	V								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			$ 403,900			$ 403,900	$ *	39

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

Facility Name & ID Number Margaret Manor North Branch # 0017178 Report Period Beginning: 1/1/14 Ending: 12/31/14

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								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								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Margaret Manor North Branch # 0017178 Report Period Beginning: 1/1/14 Ending: 12/31/14

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		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	PETER O'BRIEN	OWNER	ADMINISTRATIV	100.00	SEE ATTACHED	7	15.99	ALLOC SAL	$ 28,782	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	$ 28,782		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

Facility Name & ID Number Margaret Manor North Branch # 0017178 Report Period Beginning: 1/1/14 Ending: 12/31/14

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 MANAGEMENT
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	207,657	5	$ 4,745	$	33,202	$ 759	1
2	6	Repair & Maintenance	Patient Days	207,657	5	8,559		33,202	1,368	2
3	19	Professional Fees	Patient Days	207,657	5	39,102		33,202	6,252	3
4	20	Dues and Subscriptions	Patient Days	207,657	5	3,310		33,202	529	4
5	21	Clerical and General	Patient Days	207,657	5	925,033	874,134	33,202	147,902	5
6	25	Auto Expense	Patient Days	207,657	5	14,738		33,202	2,356	6
7	26	Insurance	Patient Days	207,657	5	22,644		33,202	3,621	7
8	27	Employee Benefits	Patient Days	207,657	5	126,715		33,202	20,260	8
9	30	Depreciation	Patient Days	207,657	5	28,736		33,202	4,595	9
10	32	Interest	Patient Days	207,657	5	31,355		33,202	5,013	10
11	33	Real Estate Taxes	Patient Days	207,657	5	17,529		33,202	2,803	11
12										12
13	17	Salary - P. O'Brien	Avg Hrs Worked		5	180,000	180,000		28,782	13
14	27	Employee Benefits	Avg Hrs Worked		5	17,815			2,849	14
15										15
16	17	Administrative Salary	Direct Allocation			550,936	550,936		58,313	16
17	27	Employee Benefits	Direct Allocation			84,158			5,230	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,055,375	$ 1,605,070		$ 290,632	25

Facility Name & ID Number Margaret Manor North Branch # 0017178 Report Period Beginning: 1/1/14 Ending: 12/31/14

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: WINDY CITY NURSING
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	1	DIETARY	DIRECT ALLOCATION	1	1	$ 7,793	$ 7,793	1	$ 7,793	1
2	10	NURSING	DIRECT ALLOCATION	1	1	158,583	158,583	1	158,583	2
3	12	SOCIAL SERVICE	DIRECT ALLOCATION	1	1	131,101	131,101	1	131,101	3
4	21	ADMINISTRATIVE CLERICAL	DIRECT ALLOCATION	1	1	43,878	43,878	1	43,878	4
5	11	ACTIVITIES	DIRECT ALLOCATION	1	1	62,545	62,545	1	62,545	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					$ 403,900	$ 403,900		$ 403,900	25

Facility Name & ID Number Margaret Manor North Branch # 0017178 Report Period Beginning: 1/1/14 Ending: 12/31/14

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	NORTH COMMUNITY BANK		X	MORTGAGE			$	$ 2,458,837			$ 104,736	1
2												2
3												3
4												4
5												5
	Working Capital											
6	BRIDGEVIEW BANK		X	LINE OF CREDIT				145,000			17,466	6
7	SIGNATURE		X	LINE OF CREDIT				287,371			12,759	7
8	WINTRUST		X	LINE OF CREDIT							88	8
9	TOTAL Facility Related						$	$ 2,891,208			$ 135,049	9
	B. Non-Facility Related*											
10												10
11	Allowable											11
12	1721 CORP	X		LINE OF CREDIT							9,713	12
13	ALLOCATED FROM MADO	X									5,013	13
14	TOTAL Non-Facility Related						$	$			$ 14,726	14
15	TOTALS (line 9+line14)						$	$ 2,891,208			$ 149,775	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** N/A **Line #** _____

*** 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 Margaret Manor North Branch # 0017178 Report Period Beginning: 1/1/14 Ending: 12/31/14

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 96,372	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.)		$ 97,068	2
3. Under or (over) accrual (line 2 minus line 1).		$ 696	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 98,978	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.)**		$	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.		$ 99,674	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2009	73,431	8
	2010	76,626	9
	2011	76,263	10
	2012	93,230	11
	2013	94,265	12

Allocated from MADO Management = $2,803

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2013	$	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.

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Margaret Manor North Branch COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0017178

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 2013 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 2013.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-17-406-005		$ 94,264.96	$ 94,264.96
2.	17-04-204-012	Home Office (see attachment)	$ 25,777.45	$ 2,802.63
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 120,042.41	$ 97,067.59

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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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.

Facility Name & ID Number Margaret Manor North Branch # 0017178 Report Period Beginning: 1/1/14 Ending: 12/31/14

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 27,000 B. General Construction Type: Exterior BRICK Frame BRICK 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			$ 20,000	1
2					2
3	TOTALS			$ 20,000	3

Facility Name & ID Number Margaret Manor North Branch # 0017178 Report Period Beginning: 1/1/14 Ending: 12/31/14

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					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1969	23,125		20				9
10	Various			1970	19,000		20				10
11	Various			1972	20,000		20				11
12	Various			1973	16,751		20				12
13	Various			1974	5,550		20				13
14	Various			1975	118,165		20				14
15	Various			1978	20,810		20				15
16	Various			1979	15,068		20				16
17	Various			1980	25,336		20			25,336	17
18	Various			1981	2,395		20			2,395	18
19	Various			1984	1,478		20			1,478	19
20	Various			1985	4,127		20			4,127	20
21	Various			1986	3,495		20			3,495	21
22	Various			1987	9,180		20			9,180	22
23	Various			1988	20,920		20			20,920	23
24	Various			1990	62,014		20			62,014	24
25	Various			1991	28,600		20			28,600	25
26	Various			1992	15,024		20	468	468	15,024	26
27	Various			1993	3,690		20			3,690	27
28	Various			1994	14,277		20	714	714	13,793	28
29	Various			1995	7,210		20	361	361	6,950	29
30	Various			1996	27,290		20	1,365	1,365	25,310	30
31	Various			1997	11,518		20	576	576	9,991	31
32	Various			1998	4,510		20	226	226	3,749	32
33	Various			1999	18,958		20	948	948	14,793	33
34	Various			2000	92,517		20	4,626	4,626	67,703	34
35	Various			2001	22,366		20	1,118	1,118	15,901	35
36	Various			2002	56,931		20			56,931	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 Margaret Manor North Branch # 0017178 Report Period Beginning: 1/1/14 Ending: 12/31/14

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	
37	Various	2003	$ 99,578	$	20	$ 4,979	$ 4,979	$ 57,213	37
38	Various	2004	112,088		20	5,604	5,604	75,566	38
39	Various	2005	26,091		20	1,305	1,305	12,703	39
40	Various	2006	7,654		20	383	383	6,339	40
41	Various	2007	21,711		20	1,086	1,086	15,062	41
42	Various	2008	83,890		20	4,195	4,195	27,763	42
43	Camera System	2010	3,162		20	158	158	711	43
44	Furnished & Installed Aluminum Windows	2010	13,450		20	673	673	3,364	44
45	400 AMP Main Distribution Panel	2010	13,485		20	674	674	3,090	45
46	Domestic Hot Water Boiler	2010	6,345		20	317	317	1,374	46
47	Additional Sprinkler Head;Repair Sprinkler System	2010	3,071		20	154	154	666	47
48	New Motor For Elevator	2010	3,090		20	155	155	658	48
49	Door & Locking Hardware	2010	3,986		20	199	199	896	49
50	Concrete Sidewalk Replacement	2012	5,950		20	298	298	596	50
51	Replaced Kitchen Range Hood	2012	9,000		20	450	450	600	51
52	Flooring -2nd Floor Hallway	2013	8,632		10	863	863	1,510	52
53	Flooring -3rd Floor Hallway	2013	4,496		10	450	450	896	53
54	Flooring Laundry Room	2013	6,415		10	642	642	957	54
55	4X8 Grease Traps	2013	3,150		10	315	315	420	55
56	Sewer Repair	2013	5,320		20	266	266	466	56
57	Hoistway elevator doors	2014	3,845		20	128	128	128	57
58	Replace Gutters and Fascia	2014	7,500		20	250	250	250	58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	F/S Depreciation			21,921			(21,921)		67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,122,214	$ 21,921		$ 33,941	$ 12,020	$ 602,603	70

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

Facility Name & ID Number Margaret Manor North Branch # 0017178 Report Period Beginning: 1/1/14 Ending: 12/31/14

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		$ 1,122,214	$ 21,921		$ 33,941	$ 12,020	$ 602,603	1
2									2
3	RELATED PARTY INFORMATION								3
4	BUILDINGS:								4
5	ALLOCATED FROM MADO MANAGEMENT	1988	33,141	1,239	35	947	(292)	17,991	5
6									6
7									7
8	LEASEHOLD IMPROVEMENTS:								8
9	MADO MANAGEMENT	1995	769		20	38	38	750	9
10	MADO MANAGEMENT	1993	12,623	336	20	631	295	13,522	10
11	MADO MANAGEMENT	2000	1,888		20	94	94	1,371	11
12	MADO MANAGEMENT	2001	818		20	41	41	561	12
13	MADO MANAGEMENT	2002	1,286		20	62	62	1,316	13
14	MADO MANAGEMENT	2004	362	4	20	18	14	186	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	TOTAL (lines 1 thru 33)		$ 1,173,101	$ 23,500		$ 35,772	$ 12,272	$ 638,300	34

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

Facility Name & ID Number Margaret Manor North Branch # 0017178 Report Period Beginning: 1/1/14 Ending: 12/31/14

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	$ 79,911	$	$ 4,936	$ 4,936	10	$ 63,585	71
72	Current Year Purchases	2,611	1,567	109	(1,458)	10	109	72
73	Fully Depreciated Assets	203,661				10	288,096	73
74								74
75	TOTALS	$ 286,183	$ 1,567	$ 5,045	$ 3,478		$ 351,790	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		FORD WAGON	1998	$ 19,707	$	$	$	5	$ 16,485	76
77		1990 FORD WAGON	1995	5,440				5	5,440	77
78		Allocated from MADO Mgmt	2010	37,623	3,016	3,326	310	5	35,236	78
79										79
80	TOTALS			$ 62,770	$ 3,016	$ 3,326	$ 310		$ 57,161	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)	$ 1,542,054	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 28,083	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 44,143	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 16,060	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,047,251	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	CAPTIAL PROJECT - 1990	$ 24,936	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 24,936	$	$	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 Margaret Manor North Branch # 0017178 Report Period Beginning: 1/1/14 Ending: 12/31/14

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
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

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: *

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.	/2015	$
13.	/2016	$
14.	/2017	$

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: $ 2,905 Description: Ice Machine $1,166; Copiers $1,739
    (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 Margaret Manor North Branch # 0017178 Report Period Beginning: 1/1/14 Ending: 12/31/14

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.

Facility Name & ID Number Margaret Manor North Branch # 0017178 Report Period Beginning: 1/1/14 Ending: 12/31/14

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		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	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 Margaret Manor North Branch # 0017178 Report Period Beginning: 1/1/14 Ending: 12/31/14

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/14 (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	$ 81,866	$	1
2	Cash-Patient Deposits	13,484		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	586,112		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	9,692		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	25,261		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 716,415	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	937,813		15
16	Equipment, at Historical Cost	360,437		16
17	Accumulated Depreciation (book methods)	(1,004,474)		17
18	Deferred Charges	1,185		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):	4,500		22
23	Other(specify):	117,978		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 417,439	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,133,854	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 644,182	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,100		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	12,475		30
31	Accrued Taxes Payable (excluding real estate taxes)	419		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 658,176	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	432,371		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 432,371	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,090,547	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 43,307	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,133,854	$	48

***(See instructions.)**

Facility Name & ID Number Margaret Manor North Branch # 0017178 Report Period Beginning: 1/1/14 Ending: 12/31/14

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,589,470	1	
2	Restatements (describe):		2	
3	**Prior Period Adjs**	3,815	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,593,285	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	245,050	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	(3,795,028)	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)**	$ (3,549,978)	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)**	$ 43,307	24	*

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

Facility Name & ID Number Margaret Manor North Branch # 0017178 Report Period Beginning: 1/1/14 Ending: 12/31/14

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	$ 3,610,332	1
2	Discounts and Allowances for all Levels	(4,343)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,605,989	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	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	4,605	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		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 4,605	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.)		27
28	MISC INCOME & LOSS ON ASSET DISPOSAL	(1,430)	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ (1,430)	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,609,164	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,110,811	31
32	Health Care	1,131,315	32
33	General Administration	839,277	33
	B. Capital Expense		
34	Ownership	276,418	34
	C. Ancillary Expense		
35	Special Cost Centers	6,293	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,364,114	40
41	**Income before Income Taxes (line 30 minus line 40)****	245,050	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 245,050	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,574,799	44
45	Private Pay - Net Inpatient Revenue	61,810	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) PRIOR YEAR ADJ	(26,277)	47
48	Other-(specify) BAD DEBT EXPENSE	(4,343)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,605,989	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 Margaret Manor North Branch # 0017178 Report Period Beginning: 1/1/14 Ending: 12/31/14

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing			$	$	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,521	3,639	90,060	24.75	3
4	Licensed Practical Nurses	4,722	4,859	111,702	22.99	4
5	CNAs & Orderlies	26,352	27,841	313,564	11.26	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	15	17	375	22.06	9
10	Activity Assistants	8,521	9,086	86,869	9.56	10
11	Social Service Workers	5,758	6,332	78,401	12.38	11
12	Dietician					12
13	Food Service Supervisor	10,416	11,268	128,508	11.40	13
14	Head Cook					14
15	Cook Helpers/Assistants	3,449	3,860	34,597	8.96	15
16	Dishwashers	1,429	1,686	16,275	9.65	16
17	Maintenance Workers	4,507	4,984	59,372	11.91	17
18	Housekeepers	7,999	8,779	90,747	10.34	18
19	Laundry	3,669	4,062	38,109	9.38	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	308	326	5,462	16.75	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					31
32	Other Health Care(specify)					32
33	Other(specify) SECURITY	11,481	12,140	116,175	9.57	33
34	TOTAL (lines 1 - 33)	92,147	98,879	$ 1,170,216 *	$ 11.83	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	109	$ 3,807	1-03	35
36	Medical Director	MONTHLY	6,500	9-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	12	601	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				44
45	Social Service Consultant	98	5,708	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	219	$ 16,616		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	2,458	$ 88,177	10-03	50
51	Licensed Practical Nurses	2,486	73,432	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	4,944	$ 161,609		53

Facility Name & ID Number Margaret Manor North Branch # 0017178 Report Period Beginning: 1/1/14 Ending: 12/31/14

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
Management Fees	$ 395,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 395,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
PERSONNEL PLANNERS	UNEMPLOYMENT CONS	$ 1,720
WOLF & COMPANY, LLP	ACCOUNTING	9,787
POWDERHORN CONSULTING	CONSULT FOR CARF	2,483
LIFE SAFETY RESOURCES, LLC	CONSULTANT	740
	DATA PROCESSING	7,286
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 22,016

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 24,500
Unemployment Compensation Insurance	20,615
FICA Taxes	89,092
Employee Health Insurance	49,463
Employee Meals	43,048
Illinois Municipal Retirement Fund (IMRF)*	
401K	1,732
PENSION	349
TRAINING	1,165
TOTAL (agree to Schedule V, line 22, col.8)	$ 229,964

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 116)	1,387
Patient Background Checks 41	3,580
Advertising	1,720
Licenses, Dues & Fees	12,987
MADO ALLOCATION	529
Less: Public Relations Expense	( )
Non-allowable advertising	(1,720)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 18,483

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	400
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 400

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Margaret Manor North Branch # 0017178 Report Period Beginning: 1/1/14 Ending: 12/31/14

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

Facility Name & ID Number Margaret Manor North Branch # 0017178 Report Period Beginning: 1/1/14 Ending: 12/31/14

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. $ **117** 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.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **0**
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? **N/A**

(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. $ **43,048** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(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%**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
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. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name:

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

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.