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: 0013334

Facility Name: Sacred Heart Home

Address: 1550 South Albany (Number) Chicago (City) 60623 (Zip Code)

County: Cook

Telephone Number: (773) 277-6868 **Fax #** (773) 277-5014

HFS ID Number:

Date of Initial License for Current Owners: 01/01/71

Type of Ownership:

	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 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 Sacred Heart Home # 0013334 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	172	Intermediate (ICF)	172	62,780	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	172	TOTALS	172	62,780	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	51,821	759	1,301	53,881	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	51,821	759	1,301	53,881	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.83%

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 7/1/1971

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 Sacred Heart Home # 0013334 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 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY 9	10	
	A. General Services											
1	Dietary	255,797	21,877	60,544	338,218		338,218		338,218			1
2	Food Purchase		461,011		461,011	(55,321)	405,690	(243)	405,447			2
3	Housekeeping	225,990	93,870		319,860		319,860		319,860			3
4	Laundry	99,833	42,155		141,988		141,988		141,988			4
5	Heat and Other Utilities			127,218	127,218		127,218	(1,667)	125,551			5
6	Maintenance	158,713		97,496	256,209		256,209	(10,362)	245,847			6
7	Other (specify):*	371,531			371,531		371,531		371,531			7
8	**TOTAL General Services**	1,111,864	618,913	285,258	2,016,035	(55,321)	1,960,714	(12,272)	1,948,442			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	1,255,604	61,697	160,305	1,477,606		1,477,606		1,477,606			10
10a	Therapy											10a
11	Activities	264,583	20,069	4,578	289,230		289,230		289,230			11
12	Social Services	333,155		172,507	505,662		505,662		505,662			12
13	CNA Training											13
14	Program Transportation			19,102	19,102		19,102		19,102			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,853,342	81,766	362,492	2,297,600		2,297,600		2,297,600			16
	C. General Administration											
17	Administrative	371		618,000	618,371		618,371	(376,290)	242,081			17
18	Directors Fees											18
19	Professional Services			57,414	57,414		57,414	9,333	66,747			19
20	Dues, Fees, Subscriptions & Promotions			23,902	23,902		23,902	213	24,115			20
21	Clerical & General Office Expenses	36,249	41,966	90,272	168,487		168,487	271,453	439,940			21
22	Employee Benefits & Payroll Taxes			477,486	477,486	55,321	532,807		532,807			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,262	1,262		1,262		1,262			24
25	Other Admin. Staff Transportation							3,824	3,824			25
26	Insurance-Prop.Liab.Malpractice			226,958	226,958		226,958	1,432	228,390			26
27	Other (specify):*							59,538	59,538			27
28	**TOTAL General Administration**	36,620	41,966	1,495,294	1,573,880	55,321	1,629,201	(30,497)	1,598,704			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,001,826	742,645	2,143,044	5,887,515		5,887,515	(42,769)	5,844,746			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 Sacred Heart Home #0013334 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			81,522	81,522		81,522	80,716	162,238			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			189,736	189,736		189,736	1,378	191,114			32
33	Real Estate Taxes							11,648	11,648			33
34	Rent-Facility & Grounds			188,400	188,400		188,400	(188,400)				34
35	Rent-Equipment & Vehicles			3,961	3,961		3,961		3,961			35
36	Other (specify):* Amort. Expense			2,371	2,371		2,371		2,371			36
37	TOTAL Ownership			465,990	465,990		465,990	(94,658)	371,332			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops			3,718	3,718		3,718		3,718			40
41	Coffee and Gift Shops		21,901		21,901		21,901	(11,412)	10,489			41
42	Provider Participation Fee											42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		21,901	3,718	25,619		25,619	(11,412)	14,207			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,001,826	764,546	2,612,752	6,379,124		6,379,124	(148,839)	6,230,285			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 Sacred Heart Home # 0013334 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	(243)	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	36,876	21		18
19	Entertainment				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				24
25	Fund Raising, Advertising and Promotional	(646)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(924)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	33,284			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 68,347		$	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)	(217,186)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (217,186)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (148,839)		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**

Sacred Heart Home

ID# 0013334

Report Period Beginning: 1/1/14

Ending: 12/31/14

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	MISC INCOME	$ (48)	21	1
2	VENDING INCOME	(11,412)	41	2
3	BANK CHARGES	(4,470)	21	3
4	CAPITALIZED R&M	(8,692)	6	4
5	NONALLOWABLE LEGAL	(813)	19	5
6	ADJ TO S/L DEPR	78,518	30	6
7	FED TAX LIAB FORM 941	(3,851)	32	7
8	IOP RENTED SPACE-UTILITIES	(2,898)	5	8
9	IOP RENTED SPACE-MAINTENANCE	(3,891)	6	9
10	IOP RENTED SPACE-INSURANCE	(4,443)	26	10
11	IOP RENTED SPACE-DEPRECIATION	(5,258)	30	11
12	IOP RENTED SPACE-INTEREST	(2,907)	32	12
13	IOP RENTED SPACE-R/E TAXES	(174)	33	13
14	RE TAX ADJUSTMENT	3,623	33	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**	33,284		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Sacred Heart Home # 0013334 **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	(243)	0	0	0	0	0	0	0	0	0	0	(243)	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	(2,898)	0	1,231	0	0	0	0	0	0	0	0	(1,667)	5
6	Maintenance	(12,583)	0	2,221	0	0	0	0	0	0	0	0	(10,362)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(15,724)	0	3,452	0	0	0	0	0	0	0	0	(12,272)	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	(376,290)	0	0	0	0	0	0	0	0	(376,290)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(813)	0	10,146	0	0	0	0	0	0	0	0	9,333	19
20	Fees, Subscriptions & Promotions	(646)	0	859	0	0	0	0	0	0	0	0	213	20
21	Clerical & General Office Expenses	31,434	0	240,019	0	0	0	0	0	0	0	0	271,453	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	3,824	0	0	0	0	0	0	0	0	3,824	25
26	Insurance-Prop.Liab.Malpractice	(4,443)	0	5,875	0	0	0	0	0	0	0	0	1,432	26
27	Other (specify):*	0	0	59,538	0	0	0	0	0	0	0	0	59,538	27
28	**TOTAL General Administration**	25,532	0	(56,029)	0	0	0	0	0	0	0	0	(30,497)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	9,808	0	(52,577)	0	0	0	0	0	0	0	0	(42,769)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Sacred Heart Home # 0013334 **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 D. Ownership	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)	
30	Depreciation	73,260	0	7,456	0	0	0	0	0	0	0	0	80,716	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(6,758)	0	8,136	0	0	0	0	0	0	0	0	1,378	32
33	Real Estate Taxes	3,449	3,651	4,548	0	0	0	0	0	0	0	0	11,648	33
34	Rent-Facility & Grounds	0	(188,400)	0	0	0	0	0	0	0	0	0	(188,400)	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**	69,951	(184,749)	20,140	0	0	0	0	0	0	0	0	(94,658)	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	(11,412)	0	0	0	0	0	0	0	0	0	0	(11,412)	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**	(11,412)	0	0	0	0	0	0	0	0	0	0	(11,412)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	68,347	(184,749)	(32,437)	0	0	0	0	0	0	0	0	(148,839)	45

Facility Name & ID Number Sacred Heart Home # 0013334 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
		MARGARET MANOR NORTH	CHICAGO	Windy City Nursing	CHICAGO	OUTSIDE LABOR
		ST. MARTHA'S MANOR	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	Rent	$ 188,400	Long Term Care LP	100.00%	$	$ (188,400)	1
2	V	33	Real Estate Tax		Long Term Care LP	100.00%	3,651	3,651	2
3	V								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			$ 188,400			$ 3,651	$ * (184,749)	14

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

Facility Name & ID Number Sacred Heart Home # 0013334 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%	$ 1,231	$ 1,231	15
16	V	6	Repairs & Maintenance		Mado Management	100.00%	2,221	2,221	16
17	V	19	Professional Fees		Mado Management	100.00%	10,146	10,146	17
18	V	20	Dues and Subscriptions		Mado Management	100.00%	859	859	18
19	V	21	Clerical and General		Mado Management	100.00%	240,019	240,019	19
20	V	25	Auto Expense		Mado Management	100.00%	3,824	3,824	20
21	V	26	Insurance		Mado Management	100.00%	5,875	5,875	21
22	V	27	Employee Benefits		Mado Management	100.00%	32,879	32,879	22
23	V	30	Depreciation		Mado Management	100.00%	7,456	7,456	23
24	V	32	Interest		Mado Management	100.00%	8,136	8,136	24
25	V	33	Real Estate Taxes		Mado Management	100.00%	4,548	4,548	25
26	V								26
27	V	17	Management Fees	618,000	Mado Management	100.00%		(618,000)	27
28	V								28
29	V	17	Salary - P. O'Brien		Mado Management	100.00%	46,710	46,710	29
30	V	27	Employee Benefits		Mado Management	100.00%	4,623	4,623	30
31	V								31
32	V	17	Administrative Salary		Mado Management	100.00%	195,000	195,000	32
33	V	27	Employee Benefits		Mado Management	100.00%	22,036	22,036	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 618,000			$ 585,563	$ * (32,437)	39

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

Facility Name & ID Number Sacred Heart Home # 0013334 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	$ 56,431	WINDY CITY NURSING	100.00%	$ 56,431	$	15
16	V	10	NURSING	159,704	WINDY CITY NURSING	100.00%	159,704		16
17	V	12	SOCIAL SERVICE	158,128	WINDY CITY NURSING	100.00%	158,128		17
18	V	21	ADMINISTRATIVE CLERICAL	112,721	WINDY CITY NURSING	100.00%	112,721		18
19	V								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			$ 486,984			$ 486,984	$ *	39

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

Facility Name & ID Number Sacred Heart Home # 0013334 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 Sacred Heart Home # 0013334 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	12	25.95	ALLOC SAL	$ 46,710	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	$ 46,710		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 Sacred Heart Home # 0013334 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	$	53,881	$ 1,231	1
2	6	Repair & Maintenance	Patient Days	207,657	5	8,559		53,881	2,221	2
3	19	Professional Fees	Patient Days	207,657	5	39,102		53,881	10,146	3
4	20	Dues and Subscriptions	Patient Days	207,657	5	3,310		53,881	859	4
5	21	Clerical and General	Patient Days	207,657	5	925,033	874,134	53,881	240,019	5
6	25	Auto Expense	Patient Days	207,657	5	14,738		53,881	3,824	6
7	26	Insurance	Patient Days	207,657	5	22,644		53,881	5,875	7
8	27	Employee Benefits	Patient Days	207,657	5	126,715		53,881	32,879	8
9	30	Depreciation	Patient Days	207,657	5	28,736		53,881	7,456	9
10	32	Interest	Patient Days	207,657	5	31,355		53,881	8,136	10
11	33	Real Estate Taxes	Patient Days	207,657	5	17,529		53,881	4,548	11
12										12
13	17	Salary - P. O'Brien	Avg Hrs Worked		5	180,000	180,000		46,710	13
14	27	Employee Benefits	Avg Hrs Worked		5	17,815			4,623	14
15										15
16	17	Administrative Salary	Direct Allocation			550,936	550,936		195,000	16
17	27	Employee Benefits	Direct Allocation			84,158			22,036	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,055,375	$ 1,605,070		$ 585,563	25

Facility Name & ID Number Sacred Heart Home # 0013334 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	$ 56,431	$ 56,431	1	$ 56,431	1
2	10	NURSING	DIRECT ALLOCATION	1	1	159,704	159,704	1	159,704	2
3	12	SOCIAL SERVICE	DIRECT ALLOCATION	1	1	158,128	158,128	1	158,128	3
4	21	ADMINISTRATIVE CLERICAL	DIRECT ALLOCATION	1	1	112,721	112,721	1	112,721	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					$ 486,984	$ 486,984		$ 486,984	25

Facility Name & ID Number Sacred Heart Home # 0013334 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**		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												5
	Working Capital											
6	BRIDGEVIEW BANK		X	LINE OF CREDIT				710,800			147,387	6
7	SIGNATURE BANK		X	LINE OF CREDIT				469,742			31,418	7
8	WINTRUST		X	LINE OF CREDIT							1,226	8
9	TOTAL Facility Related						$	$ 1,180,542			$ 180,031	9
	B. Non-Facility Related*											
10	RENTED SPACE										(2,907)	10
11	Allowable											11
12	1721 CORP	X		LINE OF CREDIT							5,854	12
13	ALLOCATED FROM MADO	X									8,136	13
14	TOTAL Non-Facility Related						$	$			$ 11,083	14
15	TOTALS (line 9+line14)						$	$ 1,180,542			$ 191,114	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 Sacred Heart Home # 0013334 **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.**	$ 7,203	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.)		$ 11,550	2
3. Under or (over) accrual (line 2 minus line 1).		$ 4,347	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 7,301	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.		$ 11,648	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2009	6,959	8
	2010	7,262	9
	2011	7,432	10
	2012	6,908	11
	2013	7,002	12

Allocated from MADO Management = $4,548

	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 Sacred Heart Home COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0013334

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.	16-24-106-035		$ 1,221.29	$ 1,221.29
2.	16-24-106-036		$ 2,320.56	$ 2,320.56
3.	16-24-106-037		$ 3,460.00	$ 3,460.00
4.	17-04-204-012	Home Office (see attachment)	$ 25,777.45	$ 4,548.18
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 32,779.30	$ 11,550.03

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 Sacred Heart Home # 0013334 Report Period Beginning: 1/1/14 Ending: 12/31/14

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 79,940 B. General Construction Type: Exterior _____ Frame _____ 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).

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			$ 22,077	1
2					2
3	TOTALS			$ 22,077	3

Facility Name & ID Number Sacred Heart Home # 0013334 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	172			1971	$ 140,000	$		$	$	$ 140,000	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1973	9,000		20			9,000	9
10	Various			1975	16,880		20			16,880	10
11	Various			1976	4,234		20			4,234	11
12	Various			1977	43,234		20			43,234	12
13	Various			1978	50,867		20			50,867	13
14	Various			1979	40,393		20			40,393	14
15	Various			1980	4,392		20			4,392	15
16	Various			1981	15,817		20			15,817	16
17	Various			1982	15,180		20			15,180	17
18	Various			1984	7,505		20			7,505	18
19	Various			1985	60,377		20			60,377	19
20	Various			1986	41,792		20			41,792	20
21	Various			1987	17,344		20			17,344	21
22	Various			1988	13,840		20			13,824	22
23	Various			1989	10,568		20			10,568	23
24	Various			1990	48,324		20			48,324	24
25	Various			1991	26,113		20			25,972	25
26	Various			1992	105,671		20			105,671	26
27	Various			1993	14,487		20			14,487	27
28	Various			1994	37,950		20			37,950	28
29	N'arious			1995	38,705		20	1,935	1,935	36,768	29
30	Various			1996	34,431		20	1,722	1,722	32,992	30
31	Various			1997	62,792		20	3,140	3,140	54,810	31
32	Various			1998	73,236		20	3,662	3,662	61,359	32
33	Various			1999	51,272		20	2,564	2,564	39,666	33
34	Various			2000	120,486		20	6,024	6,024	88,092	34
35	Various			2001	159,720		20	7,986	7,986	107,463	35
36	Various			2002	148,315		20			148,315	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 Sacred Heart Home # 0013334 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	$ 140,910	$	10	$	$	$ 140,910	37
38	Various	2004	159,051		10	7,419	7,419	159,051	38
39	Various	2005	156,033		Various	9,221	9,221	86,823	39
40	Various	2006	173,699		Various	16,147	16,147	135,698	40
41	Various	2007	134,430		10	13,443	13,443	101,152	41
42	Various	2008	72,586		20	3,629	3,629	23,254	42
43	Pump Motor & Thermostatic Valve	2009	4,579		20	229	229	1,336	43
44	Removal & Repaving Of Courtyard	2009	7,000		20	350	350	1,954	44
45	New Layer Of Hot Roofing Rubber	2009	4,700		20	235	235	1,293	45
46	Doors For Resident Rooms	2009	3,352		20	168	168	909	46
47	Hot Water Heater & Installation Supplies	2009	4,564		20	228	228	1,236	47
48	Removal Of Fire Escape	2009	32,500		20	1,625	1,625	8,802	48
49	Brickwork For Doorways & Windows	2009	4,500		20	225	225	1,200	49
50	Closure Of 12 Fire Exit Doors	2009	5,056		20	253	253	1,349	50
51	Replaced Broken Pipe; Paved Hole - Courtyard	2009	2,943		20	147	147	760	51
52	Upgrade Boiler Room & Sewer	2009	2,548		20	127	127	657	52
53	Labor - Conversion Of Hobby Room To Activity Room	2009	5,355		20	268	268	1,362	53
54	Labor - Electrical Work - Nurses Station Renovation	2009	16,040		20	802	802	4,077	54
55	2Nd & 3Rd Flr Bathrooms- Tiles, Shelves, Flushometer	2009	22,471		20	1,124	1,124	6,461	55
56	Coversion Of Hobby Room To Activiy Room- Flooring, Walls, Pai	2009	4,543		20	227	227	1,192	56
57	2Nd Flr Nurses Station& Activity Rm- Tiles, Paint, Ceiling	2009	16,020		20	801	801	4,072	57
58	2Nd Flr Nurses Station & Bathroom- Fixtures, Paint, Doors	2009	5,690		20	285	285	1,517	58
59	Install & Paint Iron Fence & Gate	2009	3,900		20	195	195	1,008	59
60	Upgrade 2Nd Floor Nurses Station- Flooring, Wall Work	2009	7,633		20	382	382	1,973	60
61	Upgrade Courtyard Gate	2009	2,754		20	138	138	701	61
62	Installation Of Exterior Lighting - Courtyard	2009	9,875		20	494	494	2,757	62
63	2Nd Flr Nurses Station- Flooring, New Wall, Cabinets/Counter To	2009	14,621		20	731	731	3,716	63
64	2Nd & 3Rd Floor Security System - Cameras & Monitor	2010	4,872		20	244	244	1,178	64
65	Water Heater For Laundry	2010	4,162		10	416	416	1,768	65
66	Fire Alarm System Work	2010	3,400		20	170	170	708	66
67	Furnished And Installed Terrazzo Flooring	2010	4,300		20	215	215	1,075	67
68	Smoke Detectors & Fire Panels	2010	26,847		20	1,342	1,342	6,599	68
69	Fire Rated Doors	2010	10,594		20	530	530	2,605	69
70	TOTAL (lines 4 thru 69)		$ 2,484,453	$		$ 88,840	$ 88,840	$ 2,002,426	70

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

Facility Name & ID Number Sacred Heart Home # 0013334 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		$ 2,484,453	$		$ 88,840	$ 88,840	$ 2,002,426	1
2	Conversion Of Activity Room To Rehab Office	2010	5,843		20	292	292	1,412	2
3	Window Screens	2010	4,239		20	212	212	1,025	3
4	Compressor For Fire Pump	2010	3,705		20	185	185	895	4
5	Furnished & Installed Pedestrian Door	2010	2,828		20	141	141	683	5
6	Furnished & Replaced Broken Section Of Boiler	2010	15,125		20	756	756	3,592	6
7	Electric Upgrade & Outlets For A/C	2010	28,750		20	1,438	1,438	6,709	7
8	New Central Heating & A/C Unit	2010	18,715		20	936	936	4,523	8
9	Doors & Supplies For 1St Floor Bathroom & Stairs	2010	3,611		20	181	181	828	9
10	1St Floor Bathrooms - Plumbing	2010	12,300		20	615	615	2,819	10
11	Electrical Work On 2Nd & 3Rd Floors	2010	2,875		20	144	144	647	11
12	Upgrade Fire Sprinkler System	2010	10,842		20	542	542	2,394	12
13	Floor Tiles - Iop Project	2010	7,981		20	399	399	1,729	13
14	Ceiling Tiles And Doors For Iop Office	2010	4,007		20	200	200	867	14
15	Electrical Work For Iop Office	2010	5,075		20	254	254	1,079	15
16	New Hvac For Iop Office	2010	6,220		20	311	311	1,322	16
17	Upgrade Electrical Panel	2010	4,587		20	229	229	974	17
18	Bathroom Renovation - Walls, Plumbing, Showers, Tubs, Lighting	2010	72,577		20	3,629	3,629	14,818	18
19	Iop Office Conversion - Demolition, Drywall, Electrical, Flooring,	2010	78,375		20	3,919	3,919	16,002	19
20	Iop Office Bathroom - Doors & Supplies	2010	3,492		20	175	175	757	20
21	Sprinkler Head Installations	2010	2,945		20	147	147	613	21
22	2Nd Floor Bathrooms - Frame, Drywall, Floor, Tile, Shower Pan, F	2011	14,741		20	737	737	2,887	22
23	3Rd Floor Bathrooms - Frame, Drywall, Floor, Tile, Shower Pan, F	2011	5,231		20	262	262	1,025	23
24	Janitor Closets - New Pipes, Walls, Tile, Sinks	2011	13,358		20	668	668	2,560	24
25	Reception & Conference Rm - Walls, Doors, Duct Work, Tile, Cab	2011	33,828		10	3,383	3,383	12,968	25
26	3Rd Floor Tiage Unit - Walls, Floor, Electrical Fixtures, Doors, Sin	2011	116,104		20	5,805	5,805	19,350	26
27	Fire Sprinklers - Elevator	2011	5,884		20	294	294	1,103	27
28	Fire Sprinklers - Reception & Lounge	2011	3,077		20	154	154	577	28
29	Additional Fire Sprinklers For State Compliance	2011	6,722		20	336	336	1,232	29
30	Fire Sprinklers - Janitor Closets	2011	3,716		20	186	186	682	30
31	Fire Sprinklers - Canopy	2011	2,708		20	135	135	496	31
32	New Windows	2011	6,924		20	346	346	1,182	32
33	Fire Sprinklers - Triage	2011	6,266		20	313	313	965	33
34	TOTAL (lines 1 thru 33)		$ 2,997,104	$		$ 116,164	$ 116,164	$ 2,111,141	34

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

Facility Name & ID Number Sacred Heart Home # 0013334 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 12B, Carried Forward		$ 2,997,104	$		$ 116,164	$ 116,164	$ 2,111,141	1
2	Transitional Living Unit - Vents, Drains, Sewer Connect, Window	2011	89,875		20	4,494	4,494	17,601	2
3	Transitional Unit Construction Drawing & Permit	2011	13,959		20	698	698	2,210	3
4	Transitional Care Unit - Electrical Wiring	2012	32,285		Various	1,614	1,614	4,440	4
5	Transitional Care Unit - Fire Sprinkler System	2012	34,224		Various	1,711	1,711	4,420	5
6	Transitional Care Unit - Plumbing & Hvac	2012	10,014		Various	501	501	1,293	6
7	Transitional Care Unit - Labor & Materials	2012	98,849		Various	4,798	4,798	12,479	7
8	Transitional Care Unit - Doors	2012	9,580		27	355	355	1,175	8
9	Transitional Care Unit - Paint, Floor Tile, Adhesive Materials	2012	5,395		24	225	225	709	9
10	Transitional Care Unit - Fire Protection Windows	2012	4,285		Various	202	202	654	10
11	Transitional Care Unit - Additional Materials, Hvac, Lighting, Doo	2012	39,920		Various	1,979	1,979	4,291	11
12	Water Heater	2012	9,865		Various	456	456	1,652	12
13	Granite Kitchen Top & Sink	2012	2,950		Various	141	141	405	13
14	Gas Pipes To Range Hood	2012	8,500		Various	411	411	1,105	14
15	Replace Hydraulic Valve	2012	2,638		20	132	132	389	15
16	Elevator Repair - Head Gaskets & Hydraulic Packing	2012	2,927		20	146	146	431	16
17	Roofing Work - South & Northwest Roof Of Bldg	2012	4,900		20	245	245	723	17
18	Addressable Fire Alarm System	2013	4,300		7	614	614	1,126	18
19	MATERIALS TO MAINTAIN 2ND FLOOR - ILP	2013	2,534		20	127	127	233	19
20	SUPPLIES FOR MAINTENANCE-ILP;TRIAGE,RESIDENTS' R	2013	2,639		20	132	132	198	20
21	MATERALS FOR 2ND FLOOR; RESIDENTS' ROOM REPAIR	2013	2,759		20	138	138	264	21
22	FURNISHED & INSTALLED ONE NEW 230 VOLT IMPERIAL	2013	2,823		20	141	141	165	22
23	MATERIALS FOR IST FLOOR;BUILT 4 RESIDENTS BED&SH	2013	3,440		20	172	172	244	23
24	BATTERIES, TILE CEILINGS, FLOOR TILES; ELECTRICAL	2013	4,747		20	237	237	277	24
25	MATERIALS TO MAINTAIN-COURTYARD,TRIAGE&AROUN	2013	5,776		20	289	289	457	25
26	FURNITURE	2013	2,645		7	378	378	2,645	26
27	TEN(] 0) AIRCONDITIONERS 6000 BTU & TEN(10) UNTS 8MB	2013	3,592		5	239	239	3,352	27
28	FOUR(4) UNITS OF AIRCONDITIONERS	2013	7,097		5	355	355	6,387	28
29	ARMSTRONG PUMP	2014	1,305		10	120	120	120	29
30	ELECTRIC EYE PACKAGE FOR BACK DOOR	2014	1,158		10	87	87	87	30
31	SUPERVISORY ALARM PANEL	2014	3,900		10	293	293	293	31
32	1HP SNGL PAHSE AIR COMPRESSOR	2014	4,350		15	97	97	97	32
33	PAINTS AROUND THE BUILDING	2014	2,593		10	65	65	65	33
34	TOTAL (lines 1 thru 33)		$ 3,422,928	$		$ 137,755	$ 137,755	$ 2,181,127	34

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

Facility Name & ID Number Sacred Heart Home # 0013334 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 12C, Carried Forward		$ 3,422,928	$		$ 137,755	$ 137,755	$ 2,181,127	1
2	REPAIRED FIRE SPRINKLER SYSTEM	2014	2,765		20	58	58	58	2
3	REPAIRED PASSENGER ELEVATOR	2014	3,334		20	83	83	83	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	F/S Depreciation			66,599			(66,599)		29
30									30
31	RENTED SPACE					(5,258)	(5,258)		31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,429,027	$ 66,599		$ 132,638	$ 66,039	$ 2,181,268	34

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

Facility Name & ID Number Sacred Heart Home # 0013334 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 12D, Carried Forward		$ 3,429,027	$ 66,599		$ 132,638	$ 66,039	$ 2,181,268	1
2	Related Party Information								2
3	Buildings:								3
4	MADO Management Allocation	1988	53,782	2,010	35	1,537	(473)	29,169	4
5									5
6									6
7									7
8									8
9	Leasehold Improvements:								9
10	MADO Management Allocation	1995	1,247		20	62	62	1,217	10
11	MADO Management Allocation	1993	20,485	545	20	1,024	479	21,944	11
12	MADO Management Allocation	2000	3,064		20	153	153	2,224	12
13	MADO Management Allocation	2001	1,327		20	66	66	911	13
14	MADO Management Allocation	2002	2,088		20	101	101	2,135	14
15	MADO Management Allocation	2004	588	7	20	29	22	302	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)		$ 3,511,608	$ 69,161		$ 135,610	$ 66,449	$ 2,239,170	34

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

Facility Name & ID Number Sacred Heart Home # 0013334 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	$ 316,303	$ 12,493	$ 20,635	$ 8,142	10	$ 219,275	71
72	Current Year Purchases	4,049	2,430	595	(1,835)	5	595	72
73	Fully Depreciated Assets	222,652				10	22,652	73
74								74
75	TOTALS	$ 543,004	$ 14,923	$ 21,230	$ 6,307		$ 242,522	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		1997 Jeep Grand Cherokee	1998	$ 24,457	$	$	$	5	$ 24,457	76
77		Allocated from MADO Management		61,055	4,894	5,398	504	5	57,181	77
78										78
79										79
80	TOTALS			$ 85,512	$ 4,894	$ 5,398	$ 504		$ 81,638	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)	$ 4,162,201	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 88,978	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 162,238	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 73,260	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,563,330	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 Sacred Heart Home # 0013334 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: $ 3,961 Description: Ice Machine $1,465; Copiers $2,189; Postage Meter $307
    (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 Sacred Heart Home # 0013334 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 Sacred Heart Home # 0013334 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 Sacred Heart Home # 0013334 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	$ 190,648	$	1
2	Cash-Patient Deposits	7,557		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,201,044		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	16,366		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	60,863		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,476,478	$	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	2,705,802		15
16	Equipment, at Historical Cost	706,657		16
17	Accumulated Depreciation (book methods)	(2,038,279)		17
18	Deferred Charges			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):			22
23	Other(specify): MADO MGMT LP	894,956		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,269,136	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,745,614	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 964,242	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,950		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	25,586		30
31	Accrued Taxes Payable (excluding real estate taxes)	243		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)**	$ 992,021	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,718,694		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)**	$ 1,718,694	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,710,715	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,034,899	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,745,614	$	48

***(See instructions.)**

Facility Name & ID Number Sacred Heart Home **#** 0013334 **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**	$ 1,121,656	1
2	Restatements (describe):		2
3	**Prior Period Adjs**	13,714	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,135,370	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(100,471)	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)**	$ (100,471)	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)**	$ 1,034,899	24 *

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

Facility Name & ID Number Sacred Heart Home # 0013334 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	$ 6,191,500	1
2	Discounts and Allowances for all Levels	(17,424)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,174,076	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	11,412	12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	95,142	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)**	$ 106,554	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	(1,977)	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ (1,977)	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,278,653	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,016,035	31
32	Health Care	2,297,600	32
33	General Administration	1,573,880	33
	B. Capital Expense		
34	Ownership	465,990	34
	C. Ancillary Expense		
35	Special Cost Centers	25,619	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)***	$ 6,379,124	40
41	**Income before Income Taxes (line 30 minus line 40)****	(100,471)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (100,471)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 6,035,452	44
45	Private Pay - Net Inpatient Revenue	279,870	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) PRIOR PERIOD ADJS	(123,822)	47
48	Other-(specify) BAD DEBTS	(17,424)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 6,174,076	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 Sacred Heart Home # 0013334 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	15	17	$ 617	$ 36.29	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,594	3,802	112,639	29.63	3
4	Licensed Practical Nurses	20,807	21,789	558,898	25.65	4
5	CNAs & Orderlies	47,381	51,274	583,450	11.38	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,319	2,623	40,988	15.63	9
10	Activity Assistants	20,151	21,681	223,595	10.31	10
11	Social Service Workers	18,271	19,736	333,155	16.88	11
12	Dietician					12
13	Food Service Supervisor	3,082	3,296	37,513	11.38	13
14	Head Cook					14
15	Cook Helpers/Assistants	18,055	20,610	218,284	10.59	15
16	Dishwashers					16
17	Maintenance Workers	11,701	13,263	158,713	11.97	17
18	Housekeepers	20,061	21,865	225,990	10.34	18
19	Laundry	8,754	9,735	99,833	10.26	19
20	Administrator					20
21	Assistant Administrator	15	17	371	21.82	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,041	3,316	36,249	10.93	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	31,776	34,060	371,531	10.91	33
34	TOTAL (lines 1 - 33)	209,023	227,084	$ 3,001,826 *	$ 13.22	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	118	$ 4,113	1-03	35
36	Medical Director	MONTHLY	6,000	9-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	12	600	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	223	12,917	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	353	$ 23,630		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	4,536	$ 159,705	10-03	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	4,536	$ 159,705		53

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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	$ 618,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 618,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
PERSONNEL PLANNERS, INC	UNEMPLOYMENT CONSI	$ 1,518
WOLF & COMPANY	ACCOUNTING SERVICES	12,051
MAEMAR P.C.	ARCHITECTURAL SERVICE	22,570
POWDERN HORN CONSULTING	CONSULTANT	2,483
LIFE SAFETY RESOURCES, LLC	CONSULTANT	7,562
MISCELLANEOUS FEES	LEGAL FEES	812
	DATA PROCESSING	10,418
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 57,414

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 55,306
Unemployment Compensation Insurance	66,971
FICA Taxes	229,054
Employee Health Insurance	123,303
Employee Meals	55,321
Illinois Municipal Retirement Fund (IMRF)*	
401K	361
TRAINING	2,354
TRANSPORTATION	137
TOTAL (agree to Schedule V, line 22, col.8)	$ 532,807

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	
Health Care Worker Background Check	
(Indicate # of checks performed 1)	60
Patient Background Checks 60	740
Advertising	646
Licenses, Dues & Fees	22,456
MADO ALLOCATION	859
Less: Public Relations Expense	( )
Non-allowable advertising	(646)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 24,115

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,262
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,262

**See instructions.

Facility Name & ID Number Sacred Heart Home # 0013334 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 Sacred Heart Home # 0013334 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. $ **358** 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? **YES** 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. $ **55,321** 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 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.