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: 0023770

Facility Name: ST MARTHA MANOR

Address: 4621 N RACINE AVENUE (Number) CHICAGO (City) 60640 (Zip Code)

County: COOK

Telephone Number: (773) 784-2300 **Fax #** (773-769-4621)

HFS ID Number:

Date of Initial License for Current Owners: 12/1/1977

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 ST MARTHA MANOR # 0023770 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	57	Skilled (SNF)	57	20,805	1
2		Skilled Pediatric (SNF/PED)			2
3	75	Intermediate (ICF)	75	27,375	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	132	TOTALS	132	48,180	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	365			365	8
9	SNF/PED					9
10	ICF	45,017			45,017	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	45,382			45,382	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.19%

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 11/1/1978

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 11/1/1978 NO [ ]

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 ST MARTHA MANOR # 0023770 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	241,735	29,235	62,488	333,458		333,458		333,458			1
2	Food Purchase		363,700		363,700	(43,644)	320,056		320,056			2
3	Housekeeping	154,983	79,110		234,093		234,093		234,093			3
4	Laundry	99,070	38,092		137,162		137,162		137,162			4
5	Heat and Other Utilities			131,746	131,746		131,746	1,037	132,783			5
6	Maintenance	92,884		121,106	213,990		213,990	(1,120)	212,870			6
7	Other (specify):*	92,225			92,225		92,225		92,225			7
8	**TOTAL General Services**	680,897	510,137	315,340	1,506,374	(43,644)	1,462,730	(83)	1,462,647			8
	B. Health Care and Programs											
9	Medical Director			2,400	2,400		2,400		2,400			9
10	Nursing and Medical Records	1,541,037	160,063	434,065	2,135,165		2,135,165		2,135,165			10
10a	Therapy			2,006	2,006		2,006		2,006			10a
11	Activities	208,445	17,459	1,575	227,479		227,479		227,479			11
12	Social Services	197,092		64,159	261,251		261,251		261,251			12
13	CNA Training											13
14	Program Transportation			3,749	3,749		3,749		3,749			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,946,574	177,522	507,954	2,632,050		2,632,050		2,632,050			16
	C. General Administration											
17	Administrative	364		536,000	536,364		536,364	(391,670)	144,694			17
18	Directors Fees											18
19	Professional Services			61,496	61,496		61,496	8,545	70,041			19
20	Dues, Fees, Subscriptions & Promotions			15,224	15,224		15,224	(64)	15,160			20
21	Clerical & General Office Expenses	29,317	27,555	102,651	159,523		159,523	170,772	330,295			21
22	Employee Benefits & Payroll Taxes			475,653	475,653	43,644	519,297		519,297			22
23	Inservice Training & Education											23
24	Travel and Seminar			660	660		660		660			24
25	Other Admin. Staff Transportation							3,221	3,221			25
26	Insurance-Prop.Liab.Malpractice			173,503	173,503		173,503	4,949	178,452			26
27	Other (specify):*							52,949	52,949			27
28	**TOTAL General Administration**	29,681	27,555	1,365,187	1,422,423	43,644	1,466,067	(151,298)	1,314,769			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,657,152	715,214	2,188,481	5,560,847		5,560,847	(151,381)	5,409,466			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 ST MARTHA MANOR #0023770 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			36,876	36,876		36,876	31,757	68,633			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			49,342	49,342		49,342	40,000	89,342			32
33	Real Estate Taxes			129,868	129,868		129,868	(739)	129,129			33
34	Rent-Facility & Grounds			180,000	180,000		180,000	(180,000)				34
35	Rent-Equipment & Vehicles			6,027	6,027		6,027		6,027			35
36	Other (specify):*											36
37	**TOTAL Ownership**			402,113	402,113		402,113	(108,982)	293,131			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops			1,590	1,590		1,590		1,590			40
41	Coffee and Gift Shops		9,473		9,473		9,473	(4,784)	4,689			41
42	Provider Participation Fee			343,538	343,538		343,538		343,538			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		9,473	345,128	354,601		354,601	(4,784)	349,817			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,657,152	724,687	2,935,722	6,317,561		6,317,561	(265,147)	6,052,414			45

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

Facility Name & ID Number ST MARTHA MANOR # 0023770 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	(21,932)	21		18
19	Entertainment				19
20	Contributions	(2,400)	21		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	(787)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,585)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	7,661			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (19,043)		$	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)	(246,104)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (246,104)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (265,147)		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**

ST MARTHA MANOR

ID# **0023770**

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

Ending: **12/31/14**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	MISC INCOME	$ (109)	21	1
2	VENDING INCOME	(4,784)	41	2
3	BANK CHARGES	(5,362)	21	3
4	CAPITALIZED R&M	(2,991)	6	4
5	ADJ TO S/L DEPR	25,477	30	5
6	RE TAXES	(4,570)	33	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**	7,661		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number ST MARTHA MANOR # 0023770 **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	1,037	0	0	0	0	0	0	0	0	1,037	5
6	Maintenance	(2,991)	0	1,871	0	0	0	0	0	0	0	0	(1,120)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(2,991)	0	2,908	0	0	0	0	0	0	0	0	(83)	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	(391,670)	0	0	0	0	0	0	0	0	(391,670)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	8,545	0	0	0	0	0	0	0	0	8,545	19
20	Fees, Subscriptions & Promotions	(787)	0	723	0	0	0	0	0	0	0	0	(64)	20
21	Clerical & General Office Expenses	(31,388)	0	202,160	0	0	0	0	0	0	0	0	170,772	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	3,221	0	0	0	0	0	0	0	0	3,221	25
26	Insurance-Prop.Liab.Malpractice	0	0	4,949	0	0	0	0	0	0	0	0	4,949	26
27	Other (specify):*	0	0	52,949	0	0	0	0	0	0	0	0	52,949	27
28	**TOTAL General Administration**	(32,175)	0	(119,123)	0	0	0	0	0	0	0	0	(151,298)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(35,166)	0	(116,215)	0	0	0	0	0	0	0	0	(151,381)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number ST MARTHA MANOR **#** 0023770 **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	25,477	0	6,280	0	0	0	0	0	0	0	0	31,757	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	33,148	6,852	0	0	0	0	0	0	0	0	40,000	32
33	Real Estate Taxes	(4,570)	0	3,831	0	0	0	0	0	0	0	0	(739)	33
34	Rent-Facility & Grounds	0	(180,000)	0	0	0	0	0	0	0	0	0	(180,000)	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	20,907	(146,852)	16,963	0	0	0	0	0	0	0	0	(108,982)	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	(4,784)	0	0	0	0	0	0	0	0	0	0	(4,784)	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	(4,784)	0	0	0	0	0	0	0	0	0	0	(4,784)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(19,043)	(146,852)	(99,252)	0	0	0	0	0	0	0	0	(265,147)	45

Facility Name & ID Number ST MARTHA MANOR # 0023770 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	4621 Property LLC	CHICAGO	REAL ESTATE
		MARGARET MANOR NORTH	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	RENT	$ 180,000	4621 PROPERTY LLC	100.00%	$	$ (180,000)	1
2	V	32	INTEREST				33,148	33,148	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			$ 180,000			$ 33,148	$ * (146,852)	14

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

Facility Name & ID Number ST MARTHA MANOR # 0023770 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%	$ 1,037	$ 1,037	15
16	V	6	Repairs & Maintenance		Mado Management	100.00%	1,871	1,871	16
17	V	19	Professional Fees		Mado Management	100.00%	8,545	8,545	17
18	V	20	Dues and Subscriptions		Mado Management	100.00%	723	723	18
19	V	21	Clerical and General		Mado Management	100.00%	202,160	202,160	19
20	V	25	Auto Expense		Mado Management	100.00%	3,221	3,221	20
21	V	26	Insurance		Mado Management	100.00%	4,949	4,949	21
22	V	27	Employee Benefits		Mado Management	100.00%	27,693	27,693	22
23	V	30	Depreciation		Mado Management	100.00%	6,280	6,280	23
24	V	32	Interest		Mado Management	100.00%	6,852	6,852	24
25	V	33	Real Estate Taxes		Mado Management	100.00%	3,831	3,831	25
26	V								26
27	V	17	Management Fees	536,000	Mado Management	100.00%		(536,000)	27
28	V								28
29	V	17	Salary - P. O'Brien		Mado Management	100.00%	39,330	39,330	29
30	V	27	Employee Benefits		Mado Management	100.00%	3,893	3,893	30
31	V								31
32	V	17	Administrative Salary		Mado Management	100.00%	105,000	105,000	32
33	V	27	Employee Benefits		Mado Management	100.00%	21,363	21,363	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 536,000			$ 436,748	$ * (99,252)	39

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

Facility Name & ID Number ST MARTHA MANOR # 0023770 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	$ 58,211	WINDY CITY NURSING	100.00%	$ 58,211	$	15
16	V	10	NURSING	433,465	WINDY CITY NURSING	100.00%	433,465		16
17	V	12	SOCIAL SERVICE	58,719	WINDY CITY NURSING	100.00%	58,719		17
18	V	17	ADMINISTRATIVE	56,277	WINDY CITY NURSING	100.00%	56,277		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			$ 606,672			$ 606,672	$ *	39

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

Facility Name & ID Number ST MARTHA MANOR # 0023770 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 ST MARTHA MANOR # 0023770 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	10	21.85	ALLOC SAL	$ 39,330	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	$ 39,330		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 ST MARTHA MANOR # 0023770 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	$	45,382	$ 1,037	1
2	6	Repair & Maintenance	Patient Days	207,657	5	8,559		45,382	1,871	2
3	19	Professional Fees	Patient Days	207,657	5	39,102		45,382	8,545	3
4	20	Dues and Subscriptions	Patient Days	207,657	5	3,310		45,382	723	4
5	21	Clerical and General	Patient Days	207,657	5	925,033	874,134	45,382	202,160	5
6	25	Auto Expense	Patient Days	207,657	5	14,738		45,382	3,221	6
7	26	Insurance	Patient Days	207,657	5	22,644		45,382	4,949	7
8	27	Employee Benefits	Patient Days	207,657	5	126,715		45,382	27,693	8
9	30	Depreciation	Patient Days	207,657	5	28,736		45,382	6,280	9
10	32	Interest	Patient Days	207,657	5	31,355		45,382	6,852	10
11	33	Real Estate Taxes	Patient Days	207,657	5	17,529		45,382	3,831	11
12										12
13	17	Salary - P. O'Brien	Avg Hrs Worked		5	180,000	180,000		39,330	13
14	27	Employee Benefits	Avg Hrs Worked		5	17,815			3,893	14
15										15
16	17	Administrative Salary	Direct Allocation			550,936	550,936		105,000	16
17	27	Employee Benefits	Direct Allocation			84,158			21,363	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,055,375	$ 1,605,070		$ 436,748	25

Facility Name & ID Number ST MARTHA MANOR # 0023770 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	$ 58,211	$ 58,211	1	$ 58,211	1
2	10	NURSING	DIRECT ALLOCATION	1	1	433,465	433,465	1	433,465	2
3	12	SOCIAL SERVICE	DIRECT ALLOCATION	1	1	58,719	58,719	1	58,719	3
4	17	ADMINISTRATIVE	DIRECT ALLOCATION	1	1	56,277	56,277	1	56,277	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					$ 606,672	$ 606,672		$ 606,672	25

Facility Name & ID Number ST MARTHA MANOR # 0023770 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	BRIDGEVIEW BANK			MORTGAGE			$	$ 528,856			$ 33,148	1
2	(4621 CORP)											2
3												3
4												4
5												5
	Working Capital											
6	BRIDGEVIEW BANK		X	LINE OF CREDIT				1,543,750			26,996	6
7	SIGNATURE BANK		X	LINE OF CREDIT				613,952			21,252	7
8	WINTRUST		X	LINE OF CREDIT							1,094	8
9	TOTAL Facility Related						$	$ 2,686,558			$ 82,490	9
	B. Non-Facility Related*											
10												10
11												11
12	Allowable:											12
13	ALLOC FROM MADO MGT	X									6,852	13
14	TOTAL Non-Facility Related						$	$			$ 6,852	14
15	TOTALS (line 9+line14)						$	$ 2,686,558			$ 89,342	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 ST MARTHA MANOR # 0023770 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.**	$ 128,135	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.)		$ 127,457	2
3. Under or (over) accrual (line 2 minus line 1).		$ (678)	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 129,807	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.		$ 129,129	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2009	96,186	8
	2010	100,511	9
	2011	100,085	10
	2012	111,208	11
	2013	123,626	12

Allocated from MADO Management = $3,831

	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 ST MARTHA MANOR COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0023770

CONTACT PERSON REGARDING THIS REPORT PETER O'BRIEN

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

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.	14-17-207-006	Long Term Care Property	$ 85,252.84	$ 85,252.84
2.	14-17-207-012	Long Term Care Property	$ 1,208.83	$ 1,208.83
3.	14-17-207-013	Long Term Care Property	$ 7,541.20	$ 7,541.20
4.	14-17-207-014	4616 North Clifton (30%)	$ 15,636.70	$ 15,636.70
5.	14-17-207-019	Long Term Care Property	$ 13,986.33	$ 13,986.33
6.	17-04-204-012	Home Office	$ 25,777.45	$ 3,830.77
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 149,403.35	$ 127,456.67

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 ST MARTHA MANOR # 0023770 Report Period Beginning: 1/1/14 Ending: 12/31/14

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 35,364 B. General Construction Type: Exterior _____ Frame Fire Retardent Number of Stories 4

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	12,868	1984	$ 70,700	1
2					2
3	TOTALS	12,868		$ 70,700	3

Facility Name & ID Number ST MARTHA MANOR # 0023770 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	132		1984	1975	$ 1,494,824	$	35	$	$	$ 1,494,824	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1978	541					541	9
10	Various			1979	38,105					38,105	10
11	Various			1981	22,244					22,244	11
12	Various			1982	12,527					12,527	12
13	Various			1983	5,530					5,530	13
14	Various			1984	25,958					25,958	14
15	Various			1985	10,641					10,641	15
16	Various			1986	13,635			682	682	10,797	16
17	Various			1987	65,231					65,231	17
18	Various			1988	30,395					30,395	18
19	Various			1990	115,949					115,949	19
20	Various			1991	10,000					10,000	20
21	Various			1992	22,069					22,069	21
22	Various			1993	18,217					18,217	22
23	Various			1994	12,220					12,220	23
24	Various			1995	109,219			2,505	2,505	109,219	24
25	Various			1996	28,361			1,418	1,418	26,662	25
26	Various			1997	69,848			3,227	3,227	61,956	26
27	Various			1998	56,951			2,848	2,848	47,038	27
28	Various			1999	93,038			4,652	4,652	72,373	28
29	Various			2000	84,672			4,234	4,234	61,276	29
30	Various			2001	72,394			3,620	3,620	49,232	30
31	Various			2002	121,688					121,688	31
32	Various			2003	57,379			2,869	2,869	32,985	32
33	Various			2004	89,609			7,762	7,762	82,868	33
34	Various			2005	31,058			2,520	2,520	24,009	34
35	Various			2006	23,468			2,106	2,106	17,759	35
36	Various			2007	10,166			508	508	3,739	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number ST MARTHA MANOR # 0023770 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	2008	$ 18,781	$	20	$ 939	$ 939	$ 6,218	37
38	Replace Fire Doors	2009	3,772		20	189	189	1,022	38
39	Electrical Work In The Courtyard	2009	7,185		20	359	359	2,005	39
40	Electric Lock For Pedestrian Gate	2009	2,584		20	129	129	721	40
41	Brick Patio & Retaining Wall	2009	4,100		20	205	205	1,145	41
42	Repairs To Air Conditioning System	2009	2,685		20	134	134	716	42
43	Condensing Motor Fan	2009	4,433		20	222	222	1,220	43
44	Fire Alarm Wiring	2009	3,453		20	173	173	1,008	44
45	Therapy - Whirlpool Tub	2010	8,437		20	422	422	1,793	45
46	Furnish & Install Water Heater	2010	9,735		20	487	487	2,434	46
47	Sprinkler Heads	2010	4,769		20	238	238	1,112	47
48	Electrical Work - Elevator	2010	16,786		20	839	839	3,846	48
49	Electrical Work	2010	9,935		20	497	497	2,194	49
50	Cold Water Pressure Pump	2011	3,785		20	189	189	630	50
51	Fire Escape Improvement Per Idph Requirement	2011	17,595		20	880	880	3,446	51
52	Replaced Burned Wire, Filters For Two Compressors	2011	3,665		20	183	183	656	52
53	20 Ton Semi-Hermetic Reciprocating Compressor	2012	13,730		20	687	687	1,603	53
54	Bathroom Renovation (Ceiling, Electrical, Plumbing, Drywall, Flo	2012	8,570		20	429	429	894	54
55	Install New Dampers	2012	3,370		20	169	169	352	55
56	Sealed Wall Cracks; Rebuilt Damage Part Wall	2012	3,850		20	193	193	579	56
57	Installed New Valve And Drained Line	2012	4,654		20	233	233	699	57
58	Fire Sprinkler Repairs	2012	5,859		20	293	293	879	58
59	Fire Alarm Repairs	2012	3,762		20	188	188	564	59
60	Furnished And Installed Heating Elements For Water Heater Boo	2012	2,663		20	133	133	399	60
61	Replaced Armaflex Insulation	2012	3,546		20	177	177	531	61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,917,641	$		$ 47,538	$ 47,538	$ 2,642,718	70

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

Facility Name & ID Number ST MARTHA MANOR # 0023770 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		$ 2,917,641	$		$ 47,538	$ 47,538	$ 2,642,718	1
2									2
3	Bathrooms-2nd-4th floor north - drywall, floors, fixtures, painting	2013	31,539		20	1,577	1,577	1,611	3
4	Asphalt Resurface	2013	12,500		8	1,563	1,563	1,954	4
5	Repaired South Passenger Elevator	2013	4,021		20	201	201	335	5
6	Repaired Mop Sink	2013	2,500		20	125	125	135	6
7	Install New 50 HP 230 Volt Pump Motor	2013	3,039		15	203	203	220	7
8	Excavated 25 Feet for Washing machine Line	2013	4,300		25	172	172	229	8
9	Repaired Fire Alarm System	2013	2,509		10	251	251	502	9
10	Tamper Panel Fire Detection System	2014	15,800		10	1,580	1,580	1,580	10
11	Steam Boiler	2014	34,860		20	1,307	1,307	1,307	11
12	Steam Compressor	2014	19,670		20	574	574	574	12
13	Bathrooms-2nd-5th floor south - materials and labor to replace	2014	65,876		20	275	275	275	13
14	walls, ceilings, floors, electrical & plumbing, fixtures; painting								14
15	Elevator repair-Hydraulic valve	2014	2,991		20	13	13	13	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	F/S Depreciation			30,506			(30,506)		31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,117,246	$ 30,506		$ 55,378	$ 24,872	$ 2,651,453	34

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

Facility Name & ID Number ST MARTHA MANOR # 0023770 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		$ 3,117,246	$ 30,506		$ 55,378	$ 24,872	$ 2,651,453	1
2	Related Party								2
3	Buildings								3
4	Allocated from Mado Management	1988	45,298	1693	35	1,294	(399)	24,591	4
5	Direct Allocation from Mado	1985	21,630		35	618	618		5
6	Direct Allocation from Mado	2009	6,540		35	187	187		6
7									7
8	Leasehold Improvements								8
9	Allocated from Mado Management	1995	1,051		20	53	53	1,025	9
10	Allocated from Mado Management	1993	17,254	459	20	862	403	18,483	10
11	Allocated from Mado Management	2000	2,580		20	129	129	1,874	11
12	Allocated from Mado Management	2001	1,118		20	56	56	767	12
13	Allocated from Mado Management	2002	1,758		20	85	85	1,798	13
14	Allocated from Mado Management	2004	495	6	20	25	19	255	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)		$ 3,214,970	$ 32,664		$ 58,687	$ 26,023	$ 2,700,246	34

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

Facility Name & ID Number ST MARTHA MANOR # 0023770 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	$ 120,146	$ 5,357	$ 5,100	$ (257)	10	$ 92,678	71
72	Current Year Purchases	1,500	1,013	300	(713)	5	300	72
73	Fully Depreciated Assets	260,977					260,977	73
74								74
75	TOTALS	$ 382,623	$ 6,370	$ 5,400	$ (970)		$ 353,955	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		Allocated from MADO Mgt	2010	$ 51,425	$ 4,122	$ 4,546	$ 424	5	$ 48,162	76
77										77
78										78
79										79
80	TOTALS			$ 51,425	$ 4,122	$ 4,546	$ 424		$ 48,162	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)	$ 3,719,718	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 43,156	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 68,633	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 25,477	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,102,363	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number ST MARTHA MANOR # 0023770 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: $ 6,027 Description: Ice Machine $1,166; Vending $783; Copiers $4,078
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number ST MARTHA MANOR # 0023770 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 ST MARTHA MANOR # 0023770 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 ST MARTHA MANOR # 0023770 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	$ 92,258	$	1
2	Cash-Patient Deposits	22,004		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	813,145		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	13,271		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	(15,057)		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 925,621	$	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	1,119,684		15
16	Equipment, at Historical Cost	432,495		16
17	Accumulated Depreciation (book methods)	(1,142,824)		17
18	Deferred Charges	3,293		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):	2,634,906		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,047,554	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,973,175	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 961,104	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	2,400		28
29	Short-Term Notes Payable	2,157,702		29
30	Accrued Salaries Payable	23,593		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	129,807		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37	Due to R/P	2,173,506		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 5,448,112	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			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)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,448,112	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,474,937)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,973,175	$	48

*(See instructions.)

Facility Name & ID Number ST MARTHA MANOR # 0023770 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**	$ 689,910	1
2	Restatements (describe):		2
3	PRIOR PERIOD ADJUSTMENTS	(17,283)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 672,627	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(558,883)	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	(1,588,681)	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)**	$ (2,147,564)	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)**	$ (1,474,937)	24 *

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

Facility Name & ID Number ST MARTHA MANOR # 0023770 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	$ 5,762,649	1
2	Discounts and Allowances for all Levels	262	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,762,911	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	4,784	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)**	$ 4,784	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, ASSET DISPOSAL	(9,017)	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ (9,017)	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,758,678	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,506,374	31
32	Health Care	2,632,050	32
33	General Administration	1,422,423	33
	B. Capital Expense		
34	Ownership	402,113	34
	C. Ancillary Expense		
35	Special Cost Centers	11,063	35
36	Provider Participation Fee	343,538	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,317,561	40
41	**Income before Income Taxes (line 30 minus line 40)****	(558,883)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (558,883)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 5,758,612	44
45	Private Pay - Net Inpatient Revenue	4,037	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) Bad Debt Expense/Prior Period Adj	262	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,762,911	49

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

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

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

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

Facility Name & ID Number ST MARTHA MANOR # 0023770 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	30	34	$ 1,104	$ 32.47	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,980	7,424	206,776	27.85	3
4	Licensed Practical Nurses	21,756	22,877	569,488	24.89	4
5	CNAs & Orderlies	58,936	63,925	739,384	11.57	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,910	2,161	26,368	12.20	9
10	Activity Assistants	15,914	17,350	182,077	10.49	10
11	Social Service Workers	15,617	16,804	197,092	11.73	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	3,825	4,021	40,908	10.17	14
15	Cook Helpers/Assistants	19,162	20,158	200,827	9.96	15
16	Dishwashers					16
17	Maintenance Workers	7,221	8,076	92,884	11.50	17
18	Housekeepers	16,050	16,821	154,983	9.21	18
19	Laundry	10,109	10,534	99,070	9.40	19
20	Administrator					20
21	Assistant Administrator	15	17	364	21.41	21
22	Other Administrative					22
23	Office Manager	1,812	2,089	29,317	14.03	23
24	Clerical					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	2,039	2,158	24,285	11.25	31
32	Other Health Care(specify)					32
33	Other(specify)	7,221	8,076	92,225	11.42	33
34	TOTAL (lines 1 - 33)	188,597	202,525	$ 2,657,152 *	$ 13.12	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	3,224	$ 62,488	1-03	35
36	Medical Director		2,400	9-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	12	600	10-03	39
40	Physical Therapy Consultant	30	2,006	10a-03	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	32	1,575	11-03	44
45	Social Service Consultant	3,434	64,159	12-03	45
46	Other(specify) DON/ADON	4,041	146,868	10-03	46
47	ADMIN	2,297	56,277	21-03	47
48	MAINT	381	4,748	6-03	48
49	TOTAL (lines 35 - 48)	13,451	$ 341,121		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	7,082	$ 205,307	10-03	50
51	Licensed Practical Nurses	2,602	81,290	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	9,684	$ 286,597		53

Facility Name & ID Number ST MARTHA MANOR # 0023770 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	$ 536,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 536,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Wolf & Company, LLP	Accounting	$ 16,659
Life Safety	Consultant	7,216
Personnel Planners, Inc	Unemployment Cons	1,643
Appraisal Research Counselors	Appraisal	3,500
Maemar PC	Architectural Service	24,390
	Data Processing	8,088
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 61,496

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 55,205
Unemployment Compensation Insurance	45,264
FICA Taxes	197,595
Employee Health Insurance	127,930
Employee Meals	43,644
Illinois Municipal Retirement Fund (IMRF)*	
401K	17,528
PENSION	30,354
UNIFORMS	183
MISC/TRAINING	1,594
TOTAL (agree to Schedule V, line 22, col.8)	$ 519,297

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)	
Patient Background Checks 20	400
Advertising	787
Licenses, Dues & Fees	14,037
MADO ALLOCATION	723
Less: Public Relations Expense	( )
Non-allowable advertising	(787)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 15,160

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	660
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 660

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number ST MARTHA MANOR # 0023770 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													
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18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number ST MARTHA MANOR # 0023770 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?

(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?

(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? **5 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **24,563** 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.

(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. $ **343,538**
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. $ **43,644** 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. $ **NO**
c. What percent of all travel expense relates to transportation of nurses and patients? **100%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
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. $

(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.