FOR BHF USE

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2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

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.

I. IDPH License ID Number: 0020495

Facility Name: Brother James Court

Address: 2508 St James Road (Number) Springfield (City) 62707 (Zip Code)

County: Sangamon

Telephone Number: (217) 544-4676 **Fax #** (217) 747-5914

HFS ID Number:

Date of Initial License for Current Owners: October 1, 1975

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Mary Shade **Telephone Number:** (217) 747-5912
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 07/01/09 to 06/30/10 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) October 27, 2010 (Date)
(Type or Print Name) Ron Wampler
(Title) Administrator

Paid Preparer

(Signed) (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

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 Brother James Court # 0020495 Report Period Beginning: 07/01/09 Ending: 06/30/10

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		Intermediate (ICF)			3
4	99	Intermediate/DD	99	36,135	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	99	TOTALS	99	36,135	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	32,784	365	365	33,514	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	32,784	365	365	33,514	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.75%

D. How many bed-hold days during this year were paid by the Department?
1,261 (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)

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 10/01/1975

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 _____

IV. ACCOUNTING BASIS

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

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

Tax Year: 6/30 Fiscal Year: 6/30

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

Facility Name & ID Number Brother James Court # 0020495 Report Period Beginning: 07/01/09 Ending: 06/30/10

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	205,670	19,515	4,074	229,259		229,259		229,259			1
2	Food Purchase		186,276		186,276		186,276		186,276			2
3	Housekeeping	56,932	19,722		76,654		76,654		76,654			3
4	Laundry	54,040	6,573		60,613		60,613		60,613			4
5	Heat and Other Utilities			147,508	147,508		147,508		147,508			5
6	Maintenance	59,283	2,730	48,376	110,389		110,389		110,389			6
7	Other (specify):*											7
8	**TOTAL General Services**	375,925	234,816	199,958	810,699		810,699		810,699			8
	B. Health Care and Programs											
9	Medical Director			4,800	4,800		4,800		4,800			9
10	Nursing and Medical Records	1,502,075	37,749	1,100	1,540,924		1,540,924		1,540,924			10
10a	Therapy	22,574	86	17,295	39,955		39,955		39,955			10a
11	Activities	31,691	2,121	4,989	38,801		38,801		38,801			11
12	Social Services	155,514	817	6,000	162,331		162,331		162,331			12
13	CNA Training											13
14	Program Transportation			13,068	13,068		13,068		13,068			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,711,854	40,773	47,252	1,799,879		1,799,879		1,799,879			16
	C. General Administration											
17	Administrative	70,075			70,075		70,075		70,075			17
18	Directors Fees											18
19	Professional Services			30,199	30,199		30,199		30,199			19
20	Dues, Fees, Subscriptions & Promotions			6,406	6,406		6,406		6,406			20
21	Clerical & General Office Expenses	224,794	11,320	105,425	341,539		341,539	(71,130)	270,409			21
22	Employee Benefits & Payroll Taxes			517,326	517,326		517,326		517,326			22
23	Inservice Training & Education											23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			60,889	60,889		60,889		60,889			26
27	Other (specify):*											27
28	**TOTAL General Administration**	294,869	11,320	720,245	1,026,434		1,026,434	(71,130)	955,304			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,382,648	286,909	967,455	3,637,012		3,637,012	(71,130)	3,565,882			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 Brother James Court #0020495 Report Period Beginning: 07/01/09 Ending: 06/30/10

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			153,910	153,910		153,910	104,561	258,471			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			270,000	270,000		270,000	(270,000)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			423,910	423,910		423,910	(165,439)	258,471			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			236,176	236,176		236,176		236,176			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			236,176	236,176		236,176		236,176			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,382,648	286,909	1,627,541	4,297,098		4,297,098	(236,569)	4,060,529			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 Brother James Court # 0020495 Report Period Beginning: 07/01/09 Ending: 06/30/10

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	(72)	21,3		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	(71,058)	21,1		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (71,130)		$	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)	(165,439)	34,30	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (165,439)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (236,569)		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

Brother James Court

ID# 0020495

Report Period Beginning: 07/01/09

Ending: 06/30/10

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
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
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	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Brother James Court # 0020495 **Report Period Beginning:** 07/01/09 **Ending:** 06/30/10

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
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	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	0	0	0	0	0	0	0	0	0	0	0	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	0	0	0	0	0	0	0	0	0	0	0	0	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Brother James Court # 0020495 **Report Period Beginning:** 07/01/09 **Ending:** 06/30/10

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	0	104,561	0	0	0	0	0	0	0	0	0	104,561	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(270,000)	0	0	0	0	0	0	0	0	0	(270,000)	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**	0	(165,439)	0	0	0	0	0	0	0	0	0	(165,439)	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	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	0	(165,439)	0	0	0	0	0	0	0	0	0	(165,439)	45

Facility Name & ID Number Brother James Court # 0020495 Report Period Beginning: 07/01/09 Ending: 06/30/10

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
N/A	N/A	N/A	None	Franciscan Brothers of The Holy Cross	Springfield	Religious Order
				Springfield Development Center	Springfield	Day Training Prog.
				Weber Care Corp	Springfield	Community Living Facility

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	Facility Rent	$ 270,000	Franciscan Brothers of The Holy Cross	100.00%	$	$ (270,000)	1
2	V	30	Depreciation		Franciscan Brothers of The Holy Cross	100.00%	104,561	104,561	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			$ 270,000			$ 104,561	$ * (165,439)	14

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

Facility Name & ID Number Brother James Court # 0020495 Report Period Beginning: 07/01/09 Ending: 06/30/10

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	Bro. Gerald Voycheck	Staff Trainer		None	None	Various	30.00	Consultant	$ 3,107	21,3	1
2	Bro. Anthoney Joseph McCoy	Mission Effectiveness		None	None	20	50.00	Consultant	17,520	21,3	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 20,627		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 Brother James Court # 0020495 Report Period Beginning: 07/01/09 Ending: 06/30/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Brother James Court # 0020495 Report Period Beginning: 07/01/09 Ending: 06/30/10

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							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	**TOTAL Facility Related**						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	**TOTAL Non-Facility Related**						$	$			$	14
15	**TOTALS (line 9+line14)**						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **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 Brother James Court **#** 0020495 **Report Period Beginning:** 07/01/09 **Ending:** 06/30/10

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	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.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		$	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.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2005		8
	2006		9
	2007		10
	2008		11
	2009		12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2009	$	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.

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Brother James Court COUNTY Sangamon

FACILITY IDPH LICENSE NUMBER 0020495

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

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? 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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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 Brother James Court # 0020495 Report Period Beginning: 07/01/09 Ending: 06/30/10

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 47,210 B. General Construction Type: Exterior Brick/Stone Frame Steel Number of Stories 1

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. [ ] (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: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

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				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number Brother James Court # 0020495 Report Period Beginning: 07/01/09 Ending: 06/30/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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			1975	1975	$ 1,003,250	$	30	$	$	$ 1,003,250	4
5			1996	1996	1,251,493		30	41,716	41,716	563,172	5
6			1997	1997	1,256,490		30	41,883	41,883	507,245	6
7											7
8											8
	Improvement Type**										
9	NEW WING-HEATING AND AIR CONDITIONING			1997	18,883		30	629	629	7,920	9
10	REPAVE PARKING LOT			1986	42,236		10			42,236	10
11	PAINTING/DECORATING			1979	2,591		5			2,591	11
12	BJC-BLDG IMPROVEMENTS			1980	16,233		11			16,233	12
13	BJC-BLDG IMPROVEMENTS			1984	21,419		10			21,419	13
14	BJC-REMODELING			1987	69,555		10			69,555	14
15	BJC-WATER LINE			1987	14,120		20			14,120	15
16	INSULATION			1991	9,175		15			9,175	16
17	ELECTRICAL REPAIR			1991	613		10			613	17
18	BOILER TANK REMOVAL			1992	12,498		20	625	625	11,139	18
19	TANK ROVEAL			1992	8,500		10			8,500	19
20	DISHWASHING ROOM SEWER			1992	10,680		20			8,544	20
21	BJC-STEAM LINE			1985	14,479		10			14,479	21
22	BJC-BLDG IMPROVEMENTS			1975	19,600		24			19,600	22
23	BJC-DINING AREA REMODELING			1976	34,951		10			34,951	23
24	BJC-SIDEWALK/PATIO			1976	3,545		10			3,545	24
25	BJC-BIKE RINK			1978	2,500		50			2,500	25
26	BJC-AIR CONDITIONING SYSTEM			1979	22,876		10			22,876	26
27	BJC-SITE IMPROVEMENT			1979	1,440		26			1,440	27
28	ROOF			1979	12,166		10			12,166	28
29	ROOFING			1986	45,811		10			45,811	29
30	REMODELING			1988	46,656		10			46,656	30
31	WATER LINE			1989	3,166		20			3,166	31
32	SEWAGE TREATMENT PLANT			1990	6,411		20	321	321	6,304	32
33	TANK ROVEAL			1991	9,809		10			9,809	33
34	PARKING LOT			1992	10,452		10			10,452	34
35	PAINT RESTROOMS			1992	230		5			230	35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Brother James Court # 0020495 Report Period Beginning: 07/01/09 Ending: 06/30/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	BOILER ROOM REMODELING	1993	$ 15,106	$	20	$ 755	$ 755	$ 12,469	37
38	REPAVE PARKING LOT	1994	850		10			850	38
39	PUMP	1994	734		10			734	39
40	AIRCONDITIONER WORK	1994	943		10			943	40
41	BOILER ROOM PROJECT	1994	170,330		20	8,517	8,517	130,796	41
42	LAND IMPROVEMENT - TREES	1996	3,470		20	174	174	2,313	42
43	BJC-BLDG IMPROVEMENTS	1998	15,712		30	524	524	6,197	43
44	WATER LINE REPAIR	1999	3,102		10	233	233	3,102	44
45	LAND IMPROVEMENT - TREES	1999	25,849		20	1,292	1,292	12,494	45
46	GATE	1999	550		5			550	46
47	REMODELING	1999	5,773		10	530	530	5,773	47
48	FLOOR	2000	1,683		7			1,683	48
49	TOTAL LIFE CENTER	1998	122,261		30	4,075	4,075	47,206	49
50	PARKIGLOTBLACKTOP	2000	49,310		15	3,287	3,287	32,050	50
51	LEASEHOLD IMPROVEMENTS	1985	15,200		10			15,200	51
52	LEASEHOLD IMPROVEMENTS	1986	19,507		10			19,507	52
53	PAINTING	1987	9,922		3			9,922	53
54	STEEL DOOR	1987	6,020		10			6,020	54
55	WINDOW REPLACEMENT	1987	2,013		10			2,013	55
56	GENERATOR SWITCH	1988	3,335		10			3,335	56
57	REMODEL LOBBY	1989	156,996	5,233	30	5,233		107,717	57
58	BUS HUT	1989	4,715		15			4,715	58
59	WATER HEATER	1989	6,721		10			6,721	59
60	TRANSFER SWITCH	1989	1,127		10			1,127	60
61	HEAT-ENERGY PANEL	1989	8,633		10			8,633	61
62	LEASEHOLD IMPROVEMENTS	1989	6,629		10			6,629	62
63	ROOF REPAIR	1990	6,928		10			6,928	63
64	REMODELING	1990	6,953	232	30	232		4,674	64
65	OVERHEAD DOOR	1990	1,220		10			1,220	65
66	KITCHEN TANKS	1990	3,089		10			3,089	66
67	PLASTERING	1990	2,586		10			2,586	67
68	REMODEL CEILING	1990	2,970		10			2,970	68
69	LEASEHOLD IMPROVEMENTS	1990	26,015		10			26,015	69
70	TOTAL (lines 4 thru 69)		$ 4,678,080	$ 5,465		$ 110,026	$ 104,561	$ 3,015,878	70

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

Facility Name & ID Number Brother James Court # 0020495 Report Period Beginning: 07/01/09 Ending: 06/30/10

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 4,678,080	$ 5,465		$ 110,026	$ 104,561	$ 3,015,878	1
2	LEASEHOLD IMPROVEMENTS	1991	2,141		10			2,141	2
3	WINDOW REPLACEMENT	1992	2,750		10			2,750	3
4	CARETERIA DOORS	1993	11,918		10			11,918	4
5	PLUMBING WORK	1994	6,858		10			6,858	5
6	PAINTING	1995	3,076		10			3,076	6
7	WALL AND DOOR REPAIR	1995	2,596		10			2,596	7
8	DOOR	1996	656		10			656	8
9	ROOF REPAIR	1996	5,985		10			5,985	9
10	PAINTING	1996	1,620		3			1,620	10
11	FURNACE	1996	502		10			502	11
12	LAND IMPROVEMENTS	1996	1,385		3			1,385	12
13	REPAIRS	1996	10,702		5			10,702	13
14	GRIP CAPS	1996	1,575		5			1,575	14
15	BOILER	1996	3,335		10			3,335	15
16	BEDDING	1996	1,505		3			1,505	16
17	AIR DEFLECTORS	1996	381		3			381	17
18	SHOWER	1996	259		5			259	18
19	SEWER	1996	9,387		10			9,387	19
20	PAINTING	1996	4,928		10			4,928	20
21	ROOF REPAIR	1997	798		10			798	21
22	DRAPES	1997	4,500		5			4,500	22
23	FLOOR COVERINGS	1997	1,722		10			1,722	23
24	DRAPES - LIFE CENTER	1997	3,153		5			3,153	24
25	FLOOR COVERING - LIFE CENTER	1997	4,422		10			4,422	25
26	PAINTING - LIFE CENTER	1997	8,917		10			8,917	26
27	FLOOR	1997	2,658		10			2,658	27
28	ALARM/SMOKE DETECTORS	1998	20,108		5			20,108	28
29	SNACK LOUNGE REMODELING	1999	2,847		5			2,847	29
30	ROOF REPAIRS	1999	846		10			846	30
31	CARPET - FRONT OFFICE	1999	8,881		5			8,881	31
32	YARD SIGNS	1999	2,825		10			2,825	32
33	NEW TEES AND VALVES	1999	11,685		10			11,685	33
34	TOTAL (lines 1 thru 33)		$ 4,823,001	$ 5,465		$ 110,026	$ 104,561	$ 3,160,799	34

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

Facility Name & ID Number Brother James Court # 0020495 Report Period Beginning: 07/01/09 Ending: 06/30/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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		$ 4,823,001	$ 5,465		$ 110,026	$ 104,561	$ 3,160,799	1
2	VINYL WALL COVERING	1999	1,127		10			1,127	2
3	SHOWER ROOM REPAIRS	1999	8,220		10			8,220	3
4	CONNECTION FEES FOR SEWER PROJECT	1998	7,438		10			7,438	4
5	TREE REMOVAL	1999	9,857	164	10	164		9,857	5
6	CONDENSOR	1999	12,396	207	10	207		12,396	6
7	LEASEHOLD IMPROVEMENTS	1999	2,598		5			2,598	7
8	LANDSCAPING	1999	18,255	533	10	533		18,255	8
9	DROP ROD ASSEMBLY	1999	6,408	160	10	160		6,408	9
10	FENCING	1999	3,840	128	10	128		3,840	10
11	TREES	1999	9,905	413	10	413		9,905	11
12	ROOF REPAIRS	2000	2,300	153	10	153		2,300	12
13	TILE FLOOR - RESIDENT WING	2000	34,740	2,316	10	2,316		34,740	13
14	PAINTING	2000	6,352		5			6,352	14
15	WINDOW REPLACEMENT	2000	2,009	151	10	151		3,009	15
16	LEASEHOLD IMPROVEMENTS	2000	5,754		5			5,754	16
17	CABINET MODIFICATIONS	1999	4,520		7			4,520	17
18	PROFESSIONAL ELECTRICAL SERVICES	1999	17,410	1,161	15	1,161		12,767	18
19	NEW SIGN FRONT	1999	900		5			900	19
20	BJC - MASONRY WORK	1999	23,465	1,564	15	1,564		17,208	20
21	PROFESSIONA; PLUMBING AND HEATING	1999	31,000	2,067	15	2,067		22,733	21
22	REMODELING	1999	19,524	1,302	15	1,302		14,318	22
23	PARKING LOT STRIPING	2000	1,549		5			1,549	23
24	PAINT BASEMENT CEILING	2000	664		5			664	24
25	DRAPERIES	2001	10,881		5			10,881	25
26	RAMP AREA DECORATING	2001	14,387		5			14,387	26
27	PAINTING AND WALLCOVERING	2001	8,058		5			8,058	27
28	AIR CURTAIN	2001	1,812		7			1,812	28
29	RECEPTICLES - BEDROOMS	2001	9,820		5			9,820	29
30	SHOWER ROOM FLOOR REPAIRS	2002	1,123	112	10	112		955	30
31	DOOR REPAIRS	2002	6,197	620	10	620		5,176	31
32	BOILER REPAIRS	2002	3,960		5			3,960	32
33	DRAPERIES	2002	4,200		5			4,200	33
34	TOTAL (lines 1 thru 33)		$ 5,113,670	$ 16,516		$ 121,077	$ 104,561	$ 3,426,906	34

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

Facility Name & ID Number Brother James Court # 0020495 Report Period Beginning: 07/01/09 Ending: 06/30/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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		$ 5,113,670	$ 16,516		$ 121,077	$ 104,561	$ 3,426,906	1
2	ARCHITECT FEES - REMODEL BATHROOM AREAS	2002	9,863		3			9,863	2
3	REPAVE SIDEWALKS	2002	810	81	10	81		668	3
4	TUCKPOINTING	2002	1,490	149	10	149		1,217	4
5	REPAIR FLOORS	2002	2,688	269	10	269		2,195	5
6	KEYLOCK PAD	2002	580	58	10	58		459	6
7	STRIP AND REFINISH FLOORS	2002	8,702	870	10	870		6,692	7
8	HOT WATER STORAGE TANK	2002	4,408	441	10	441		3,306	8
9	DOORS AND FRAMES	2003	3,733	373	10	373		2,706	9
10	POLE LIGHTING - WEST PARKING LOT	2004	3,740	249	15	249		1,641	10
11	SINK FAUCET AND CABINET	2004	1,133	162	7	162		1,025	11
12	WALLPAPERING/PAINTING	2004	2,358	157	15	157		943	12
13	DOORS AND FRAMES	2004	4,987	332	15	332		2,050	13
14	CEILING FANS	2004	1,082	155	7	155		953	14
15	ELECTRICAL WORK	2004	16,000	1,067	15	1,067		6,400	15
16	ALARM SYSTEM	2004	2,204	315	7	315		1,889	16
17	BOILER - KITCHEN STEAMER	2004	4,871	696	7	696		4,291	17
18	BOILER	2004	6,900	986	7	986		6,325	18
19	BOILER	2004	7,200	1,029	7	1,029		6,171	19
20	TOILET ROOM ADDITION/RENOVATION	2003	699,826	23,328	30	23,328		152,343	20
21	PARKING LOT	2004	3,443	344	30	344		1,722	21
22	HVAC LABOR/MATERIAL	2004	12,497	1,785	7	1,785		10,563	22
23	PARKING LOT	2004	74,847	2,495	30	2,495		14,762	23
24	DENTAL OFFICE RENOVATION	2004	57,955	1,932	30	1,932		11,108	24
25	POLE LIGHT REPLACEMENT	2004	1,868	267	7	267		1,512	25
26	PARKING LOT SECURITY SYSTEM	2005	20,404	2,915	7	2,915		16,023	26
27	STORAGE ROOM	2005	2,375	339	7	339		1,979	27
28	BATHROOM REPAIR	2006	4,232	846	5	846		4,162	28
29	ALARM FOR BUILDING	2006	3,000	300	10	300		1,425	29
30	ALARM FOR BUILDING	2006	3,041	304	10	304		1,394	30
31	ROOF	2006	22,370	1,118	20	1,118		5,126	31
32	WATER HEATER	2006	32,250	3,225	10	3,225		14,244	32
33	BOILER	2007	4,611	659	7	659		2,415	33
34	TOTAL (lines 1 thru 33)		$ 6,139,138	$ 63,762		$ 168,323	$ 104,561	$ 3,724,478	34

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

Facility Name & ID Number Brother James Court # 0020495 Report Period Beginning: 07/01/09 Ending: 06/30/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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		$ 6,139,138	$ 63,762		$ 168,323	$ 104,561	$ 3,724,478	1
2	BATHROOM REPAIRS	2007	6,959	994	7	994		3,645	2
3	GENERATOR	2007	2,814	563	5	563		2,017	3
4	ALARM FOR BUILDING	2007	3,325	333	10	333		1,025	4
5	NEW ROOF	2008	90,882	3,029	30	3,029		8,836	5
6	EXTERIOR FLOOD LIGHTS	2008	945	94	10	94		268	6
7	NEW HOT WATER HEATER	2009	76,900	7,930	10	7,930		12,095	7
8	A/C UNIT- NURSING STATION, BREAK ROOM	2009	36,921	4,029	10	4,029		4,440	8
9	ALARM SYSTEM UPGRADES	2009	1,240	124	10	124		155	9
10	BATHROOM RENOVATION	2009	3,346	478	7	478		478	10
11	SEAL AND STRIPE PARKING LOT	2009	3,315	474	7	474		474	11
12	REPAVING TRACK	2009	8,400	1,200	7	1,200		1,400	12
13	WING 300 BATHROOM RENOVATION	2009	44,169	5,784	7	5,784		5,784	13
14	REPAVE WALKING PATH	2009	1,450	173	7	173		173	14
15	REPAIR BRICK ON GARAGE	2009	12,330	925	10	925		925	15
16	REPLACE HOT &CHILLED WATER PIPING	2009	12,968	1,235	7	1,235		1,235	16
17	SEWER STATION CONSTRUCTION OF TRASH RACK	2009	15,375	1,281	7	1,281		1,281	17
18	EXTENDING MAINS TO GOOD PIPE WING 200	2009	2,787	232	7	232		232	18
19	REPAIR BOILER ROOM ROOF	2010	15,462	129	30	129		129	19
20	LIGHT FIXTURES FOR FRONT ENTRANCE	2010	4,791	160	5	160		160	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)		$ 6,483,517	$ 92,929		$ 197,490	$ 104,561	$ 3,769,230	34

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

Facility Name & ID Number Brother James Court # 0020495 Report Period Beginning: 07/01/09 Ending: 06/30/10

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	$ 225,191	$ 30,076	$ 30,074	$ (2)		$ 213,037	71
72	Current Year Purchases	39,738	5,054	5,054			5,054	72
73	Fully Depreciated Assets	1,543,000					1,589,838	73
74								74
75	TOTALS	$ 1,807,929	$ 35,130	$ 35,128	$ (2)		$ 1,807,929	75

D. Vehicle Depreciation (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	Facility Use	Trucks - 00 Isuzu/08 Ford	2000/2008	$ 43,165	$ 6,845	$ 6,845	$		$ 22,060	76
77	Resident Transporation	Vans/Wheelchair Lift	Various	102,455	15,032	15,032			45,231	77
78	Resident Transporation	Autos - Fully Depreciated	Various	42,640					41,448	78
79	Resident Transporation	Autos - 06 Buick/10 Sebring	2006/2010	36,828	3,976	3,976			18,344	79
80	TOTALS			$ 225,088	$ 25,853	$ 25,853	$		$ 127,083	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)	$ 8,516,534	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 153,912	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 258,471	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 104,559	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 5,704,242	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 Brother James Court # 0020495 Report Period Beginning: 07/01/09 Ending: 06/30/10

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: FRANCISCAN BROTHERS OF THE HOLY CROSS
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 [X] 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 [X] NO Terms: *

10. Effective dates of current rental agreement:
Beginning 1975
Ending 2011

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

	Fiscal Year Ending	Annual Rent
12.	/2011	$ 270,000
13.	/2012	$
14.	/2013	$

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

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ NONE Description:
(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 Brother James Court # 0020495 Report Period Beginning: 07/01/09 Ending: 06/30/10

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? [X] YES [ ] 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 [X]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER CNA 40

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- HOURS PER CNA 80

B. EXPENSES

ALLOCATION OF COSTS (d)

			1	2	3	4
			Facility			
			Drop-outs	Completed	Contract	Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies			325		325
3	Classroom Wages	(a)		5,126		5,126
4	Clinical Wages	(b)		10,252		10,252
5	In-House Trainer Wages	(c)		4,151		4,151
6	Transportation					
7	Contractual Payments					
8	CNA Competency Tests					
9	TOTALS		$	$ 19,854	$	$ 19,854
10	SUM OF line 9, col. 1 and 2	(e)	$ 19,854			

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	13
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	13

(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 Brother James Court # 0020495 Report Period Beginning: 07/01/09 Ending: 06/30/10

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.

Facility Name & ID Number Brother James Court # 0020495 Report Period Beginning: 07/01/09 Ending: 06/30/10

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/10 (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	$ 2,219,087	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	792,280		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,011,367	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	1,162,167		12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	2,105,027		15
16	Equipment, at Historical Cost	2,048,249		16
17	Accumulated Depreciation (book methods)	(2,806,052)		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):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,509,391	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,520,758	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 73,815	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	56,804		30
31	Accrued Taxes Payable (excluding real estate taxes)			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	ACCRUED VACATION	87,884		36
37	ACCRUED PENSION, OTHER W/H	92,210		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 310,713	$	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)**	$ 310,713	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 5,210,028	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,520,741	$	48

***(See instructions.)**

Facility Name & ID Number Brother James Court # 0020495 **Report Period Beginning:** 07/01/09 **Ending:** 06/30/10

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 5,034,846	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 5,034,846	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	175,182	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)**	$ 175,182	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 5,210,028	24 *

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

Facility Name & ID Number Brother James Court # 0020495 Report Period Beginning: 07/01/09 Ending: 06/30/10

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,194,924	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,194,924	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	7,534	11
12	Gift and Coffee Shop		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	30,203	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 37,737	23
	D. Non-Operating Revenue		
24	Contributions	163,308	24
25	Interest and Other Investment Income***	63,545	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 226,853	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	MISC INCOME	12,058	28
28a	CAIN ON SALE OF ASSET	708	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 12,766	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,472,280	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	810,699	31
32	Health Care	1,799,879	32
33	General Administration	1,026,434	33
	B. Capital Expense		
34	Ownership	423,910	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	236,176	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,297,098	40
41	**Income before Income Taxes (line 30 minus line 40)****	175,182	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 175,182	43

*** 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 Brother James Court # 0020495 Report Period Beginning: 07/01/09 Ending: 06/30/10

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

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,865	2,097	$ 57,804	$ 27.57	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses	15,611	16,498	302,051	18.31	4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,856	2,026	22,574	11.14	8
9	Activity Director	2,346	2,481	31,691	12.77	9
10	Activity Assistants					10
11	Social Service Workers	1,953	2,080	38,670	18.59	11
12	Dietician					12
13	Food Service Supervisor	1,984	2,180	38,309	17.57	13
14	Head Cook					14
15	Cook Helpers/Assistants	17,674	19,147	167,361	8.74	15
16	Dishwashers					16
17	Maintenance Workers	3,820	4,127	59,283	14.36	17
18	Housekeepers	5,036	5,627	56,932	10.12	18
19	Laundry	3,870	4,197	54,040	12.88	19
20	Administrator	1,928	2,080	70,075	33.69	20
21	Assistant Administrator					21
22	Other Administrative	13,626	14,706	224,794	15.29	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	7,456	8,093	116,844	14.44	28
29	Resident Services Coordinator	1,936	1,988	41,384	20.82	29
30	Habilitation Aides (DD Homes)	99,193	106,788	1,100,836	10.31	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	180,154	194,115	$ 2,382,648 *	$ 12.27	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	102	$ 4,074	1,3	35
36	Medical Director	Various	4,800	9,3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Various	1,100	10.3	39
40	Physical Therapy Consultant	44	2,393	10a,3	40
41	Occupational Therapy Consultant	3	113	10a,3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	Various	630	10a,3	43
44	Activity Consultant				44
45	Social Service Consultant	Various	6,000	12,3	45
46	Other(specify)				46
47	Psychologist Consultant	Various	14,160	10a,3	47
48					48
49	TOTAL (lines 35 - 48)	148	$ 33,269		49

C. CONTRACT NURSES

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

Facility Name & ID Number Brother James Court # 0020495 Report Period Beginning: 07/01/09 Ending: 06/30/10

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Ron Wampler	Administrator	0	$ 70,075
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 70,075

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
Sikich	Audit	$ 14,650
INB/PNC	Trust Admin	7,414
See Attached	Legal	8,135
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 30,199

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 138,282
Unemployment Compensation Insurance	32,110
FICA Taxes	170,419
Employee Health Insurance	78,144
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401(k) Contributions	81,059
Life Insurance	5,505
Education	1,438
Staff Recognition	4,954
Employee Physicals	5,415
TOTAL (agree to Schedule V, line 22, col.8)	$ 517,326

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	4,473
Health Care Worker Background Check	1,040
(Indicate # of checks performed 64)	
Patient Background Checks	
Dues and Subscriptions	893
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 6,406

G. Schedule of Travel and Seminar**

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

**See instructions.

Facility Name & ID Number Brother James Court # 0020495 Report Period Beginning: 07/01/09 Ending: 06/30/10

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 Brother James Court # 0020495 **Report Period Beginning:** 07/01/09 **Ending:** 06/30/10

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(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? **7**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **11** Line **10**

(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. $ **236,176**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **None** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **Yes** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **7,534**
c. What percent of all travel expense relates to transportation of nurses and patients? **100%**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Sikich LLP**

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

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