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: 0044784

Facility Name: St Benedict Nursing & Rehab

Address: 6930 West Touhy Avenue (Number) Niles (City) 60714 (Zip Code)

County: Cook

Telephone Number: (847) 647-0003 **Fax #** (847) 647-1936

HFS ID Number:

Date of Initial License for Current Owners: 03/01/2000

Type of Ownership:

x	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
x	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code	501(c)(3)		Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Leo Jancila **Telephone Number:** 630-530-7100
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 7/1/2009 to 6/30/2010 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) 10/29/2010 (Date)
(Type or Print Name)
(Title)

Paid Preparer

(Signed) 10/29/2010 (Date)
(Print Name and Title) Leo Jancila, Consultant
(Firm Name & Address) Strategic Reimbursement, Inc., 360 W. Butterfield Rd. Elmhurst, IL 60126
(Telephone) 630-530-7100 Fax # 630-530-7106

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 Benedict Nursing & Rehab # 0044784 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

III. STATISTICAL DATA

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

	1 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	99	Skilled (SNF)	99	36,135	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	99	TOTALS	99	36,135	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	6,339	9,151	18,886	34,376	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	6,339	9,151	18,886	34,376	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.13%

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 [X] NO [ ]

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

I. On what date did you start providing long term care at this location?
Date started 3/1/2000

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 3/1/2000 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 99 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: 6/30/2010 Fiscal Year: 6/30/2010

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

Facility Name & ID Number St Benedict Nursing & Rehab # 0044784 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

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	413,538	82,689	1,623	497,850		497,850	(117,054)	380,796			1
2	Food Purchase		284,090		284,090		284,090	(63,039)	221,051			2
3	Housekeeping	167,630		60	167,690		167,690	(37,210)	130,480			3
4	Laundry	175,084	53,806		228,890		228,890	(68,766)	160,124			4
5	Heat and Other Utilities			210,918	210,918		210,918	(46,802)	164,116			5
6	Maintenance	108,494	5,737	154,630	268,861		268,861	(59,928)	208,933			6
7	Other (specify):*											7
8	**TOTAL General Services**	864,746	426,322	367,231	1,658,299		1,658,299	(392,799)	1,265,500			8
	B. Health Care and Programs											
9	Medical Director			18,504	18,504		18,504		18,504			9
10	Nursing and Medical Records	2,202,429	108,546	38,177	2,349,152		2,349,152		2,349,152			10
10a	Therapy	359,587	994	113,039	473,620		473,620		473,620			10a
11	Activities	148,853	17,055	51	165,959		165,959		165,959			11
12	Social Services	114,834	12,808	2,860	130,502		130,502		130,502			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,825,703	139,403	172,631	3,137,737		3,137,737		3,137,737			16
	C. General Administration											
17	Administrative	69,480		1,060,142	1,129,622		1,129,622	(1,060,142)	69,480			17
18	Directors Fees											18
19	Professional Services											19
20	Dues, Fees, Subscriptions & Promotions			6,604	6,604		6,604		6,604			20
21	Clerical & General Office Expenses	215,395	9,412	27,614	252,421		252,421	561,258	813,679			21
22	Employee Benefits & Payroll Taxes			1,711,620	1,711,620		1,711,620	(60,867)	1,650,753			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,852	1,852		1,852		1,852			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			(17,256)	(17,256)		(17,256)		(17,256)			26
27	Other (specify):*											27
28	**TOTAL General Administration**	284,875	9,412	2,790,576	3,084,863		3,084,863	(559,751)	2,525,112			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,975,324	575,137	3,330,438	7,880,899		7,880,899	(952,550)	6,928,349			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 Benedict Nursing & Rehab #0044784 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

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			276,231	276,231		276,231	17,563	293,794			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			68,894	68,894		68,894	(121,182)	(52,288)			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			3,941	3,941		3,941		3,941			35
36	Other (specify):*											36
37	TOTAL Ownership			349,066	349,066		349,066	(103,619)	245,447			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		718,837		718,837		718,837		718,837			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			54,203	54,203		54,203		54,203			42
43	Other (specify):*	105,583			105,583		105,583	(105,583)				43
44	TOTAL Special Cost Centers	105,583	718,837	54,203	878,623		878,623	(105,583)	773,040			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,080,907	1,293,974	3,733,707	9,108,588		9,108,588	(1,161,752)	7,946,836			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 Benedict Nursing & Rehab # 0044784 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

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	(6,583)	1		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	(17,976)	4		8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(68,894)	32		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				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	(14,282)	21		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)**	$ (107,735)		$	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)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (107,735)		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

St Benedict Nursing & Rehab

ID# 0044784

Report Period Beginning: 7/1/2009

Ending: 6/30/2010

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Disallow Assisted Living wages	$ (105,583)	43	1
2	Disallow employee benefits allocated to Assisted Living	(124,764)	22	2
3	Disallow maintenance costs allocated to Assisted Living	(59,928)	6	3
4	Disallow utilities allocated to Assisted Living	(46,802)	5	4
5	Disallow dietary costs allocated to Assisted Living	(110,471)	1	5
6	Disallow food expense allocated to Assisted Living	(63,039)	2	6
7	Disallow laundry costs allocated to Assisted Living	(50,790)	4	7
8	Disallow depreciation allocated to non-care	(45,675)	30	8
9	Disallow housekeeping costs allocated to Assisted Living	(37,210)	3	9
10				10
11				11
12	misc income	(22,666)	21	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**	(666,928)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number St Benedict Nursing & Rehab # 0044784 **Report Period Beginning:** 7/1/2009 **Ending:** 6/30/2010

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	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary	(117,054)	0	0	0	0	0	0	0	0	0	0	(117,054)	1
2	Food Purchase	(63,039)	0	0	0	0	0	0	0	0	0	0	(63,039)	2
3	Housekeeping	(37,210)	0	0	0	0	0	0	0	0	0	0	(37,210)	3
4	Laundry	(68,766)	0	0	0	0	0	0	0	0	0	0	(68,766)	4
5	Heat and Other Utilities	(46,802)	0	0	0	0	0	0	0	0	0	0	(46,802)	5
6	Maintenance	(59,928)	0	0	0	0	0	0	0	0	0	0	(59,928)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(392,799)	0	0	0	0	0	0	0	0	0	0	(392,799)	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	(1,060,142)	0	0	0	0	0	0	0	0	0	(1,060,142)	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	(36,948)	598,206	0	0	0	0	0	0	0	0	0	561,258	21
22	Employee Benefits & Payroll Taxes	(124,764)	63,897	0	0	0	0	0	0	0	0	0	(60,867)	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**	(161,712)	(398,039)	0	0	0	0	0	0	0	0	0	(559,751)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(554,511)	(398,039)	0	0	0	0	0	0	0	0	0	(952,550)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number St Benedict Nursing & Rehab # 0044784 **Report Period Beginning:** 7/1/2009 **Ending:** 6/30/2010

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	(45,675)	63,238	0	0	0	0	0	0	0	0	0	17,563	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(68,894)	(52,288)	0	0	0	0	0	0	0	0	0	(121,182)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	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**	(114,569)	10,950	0	0	0	0	0	0	0	0	0	(103,619)	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):*	(105,583)	0	0	0	0	0	0	0	0	0	0	(105,583)	43
44	**TOTAL Special Cost Centers**	(105,583)	0	0	0	0	0	0	0	0	0	0	(105,583)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(774,663)	(387,089)	0	0	0	0	0	0	0	0	0	(1,161,752)	45

Facility Name & ID Number St Benedict Nursing & Rehab # 0044784 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

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
Resurrection Health Care	100	See Attached		See Attached		

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	21	Clerical & data processing	$	Resurrection Health Care	100.00%	$ 598,206	$ 598,206	1
2	V	22	Employee benefits		Resurrection Health Care	100.00%	63,897	63,897	2
3	V	30	Depreciation		Resurrection Health Care	100.00%	63,238	63,238	3
4	V	32	Interest	68,894	Resurrection Health Care	100.00%	16,606	(52,288)	4
5	V								5
6	V								6
7	V	17	Intercompany expense	1,060,142	Resurrection Health Care	100.00%		(1,060,142)	7
8	V	39	Intercompany pharmacy	703,763	Resurrection Health Care	100.00%	703,763		8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,832,799			$ 1,445,710	$ * (387,089)	14

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

Resurrection Health Care
Schedule for Form 990
Page 5, Part VI, Line 80b
Related Organizations
Twelve Months Ending June 30, 2010

Related Organizations	Fed Tax ID No	Tax Status
Family Medical Network	36-3961066	Non-Exempt
Holy Family Health Care Systems, Inc.	36-3495969	Exempt
Holy Family Nursing & Rehab Center	36-3121158	Exempt
Holy Family Medical Center	36-2439318	Exempt
Key Opportunities Inc.	36-3499869	Non-Exempt
L. Gilbraith Insurance SPC Ltd.		Non-Exempt
Mount Loretto Nursing Home	14-1363014	Exempt
Our Lady of Resurrection Medical Center	36-2644178	Exempt
Proviso Family Services, Inc. - DBA Resurrection Behavioral Health	36-2709982	Exempt
Resurrection Development Foundation	36-3330929	Exempt
Resurrection Health Care	36-2235165	Exempt
Resurrection Health Care Preferred, Inc.	36-3974620	Non-Exempt
Resurrection Home Health Foundation	36-3466794	Exempt
Resurrection Home Health Services	36-2893936	Exempt
Resurrection Medical Center	36-3330926	Exempt
Resurrection Rest Home	14-1348691	Exempt
Resurrection Senior Services	23-7061646	Exempt
Resurrection Services	36-3330928	Exempt
Saint Francis Hospital of Evanston	36-2167800	Exempt
Saint Joseph Hospital	36-3200170	Exempt
Saints Mary and Elizabeth Medical Center	36-2171079	Exempt
Saint Mary of Nazareth PHO	36-4006358	Non-Exempt
Stamana, Inc.	36-3314912	Non-Exempt
Westlake Community Hospital	36-1649520	Exempt
West Suburban Health Providers	36-3980942	Non-Exempt
West Suburban Health Services	36-4286236	Exempt
West Suburban Medical Center	36-2182170	Exempt

RESURRECTION SENIOR SERVICES
BOARD OF DIRECTORS
OCTOBER 1, 2009

Name	Office
Mr. Joseph F. Toomey	President and CEO Resurrection Health Care 7435 W. Talcott Avenue, Suite 520 Chicago, IL 60631 Phone: 773-792-5555; Fax 773-990-8601 Email: DEJesus-ortiz@reshealthcare.org
Sister Donna Marie Wolowicki, C.R.	Executive Vice President/CEO Resurrection Health Care 7435 W. Talcott Avenue, Suite 520 Chicago, IL 60631 Phone: 773-792-5153; Fax - 773-990-7626 Email: srdmarie@reshealthcare.org
Mr. John R. Walton	Group Executive Vice President/CEO Senior Services Holy Family Medical Center 100 North River Road Des Plaines, IL 60016 Phone: 847-813-3160 ; Fax: 847-813-3876 Email: Jwalton@reshealthcare.org
Michael Rosenberg, M.D.	Director, Emergency Medicine Resurrection Medical Center 7435 W. Talcott Avenue, Suite 520 Chicago, IL 60631 Phone: 773-792-5219; Fax 773-594-7980 Email: Morsenberg@reshealthcare.org Director, Emergency Medicine Our Lady of the Resurrection Medical Center 5645 W. Addison Chicago, IL 60634 Phone: 773-794-7602; Fax 773-794-7664 Email: Morsenberg@reshealthcare.org
Sister Elizabeth Trembczynski, CSFN	Administrator Case San Carlo Retirement Community 420 N. Wolf Road Northlake, IL 60164 Phone: 708-561-4300; Fax - 708-562-5677 Email: Etrem@reshealthcare.org

RESURRECTION SENIOR SERVICES
Board of Directors

RESURRECTION SENIOR SERVICES
OFFICERS
OCTOBER 1, 2009

Title	Name
President	Mr. Joseph F. Toomey
Group Vice President and EVP/CEO	Mr. John R. Walton
Secretary	Mr. Jeannie C. Frey
Treasurer	
Assistance Secretary	Mr. John R. Walton

Facility Name & ID Number St Benedict Nursing & Rehab # 0044784 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

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	See attached pg. 7A								$		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	$		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 Benedict Nursing & Rehab # 0044784 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

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: Resurrection Health Care/Medical Center
Street Address: 7435 West Talcott
City / State / Zip Code: Chicago, IL 60631
Phone Number: ((773) 774-8000
Fax Number: ((773) 594-7488

	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	21	Clerical & data processing				$	$		$ 598,206	1
2	22	Employee benefits							63,897	2
3	30	Depreciation							63,238	3
4	32	Interest							16,606	4
5										5
6										6
7	39	Intercompany Pharmacy							703,763	7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 1,445,710	25

Facility Name & ID Number St Benedict Nursing & Rehab # 0044784 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

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								Investment Fees			14,812	10
11								Allocated from Home Office			16,606	11
12								Interest Income Offset			(16,606)	12
13								Disallow non-allowable interest			(14,812)	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.)**

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME St Benedict Nursing & Rehab COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0044784

CONTACT PERSON REGARDING THIS REPORT Thomas W. Groenwald

TELEPHONE (773) 594-7837 FAX #: (773) 594-5867

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.	Facility is a not-for-profit entity and pays no real estate tax.		$	$
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 N/A 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 St Benedict Nursing & Rehab # 0044784 **Report Period Beginning:** 7/1/2009 **Ending:** 6/30/2010

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	N/A	12

Facility is a not-for-profit entity and pays no real estate tax.

	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.

Facility Name & ID Number St Benedict Nursing & Rehab # 0044784 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 56,961 B. General Construction Type: Exterior Brick Frame Metal Number of Stories 2

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (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).

Independent Living Units

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	56,961	2000	$ 3,157,190	1
2					2
3	TOTALS	56,961		$ 3,157,190	3

Facility Name & ID Number St Benedict Nursing & Rehab # 0044784 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

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	99		2000	1991	$ 4,247,413	$	35	$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Carpet 1st & 2nd floor halls, dining & patient rooms			2000	48,482		10				9
10	Facility sign			2000	7,845		10				10
11	Grease Basin			2000	17,015		7				11
12	Alternator switches			2001	631		10				12
13	Lawn sprinkler system			2001	756		10				13
14	High velocity water jet			2000	322		10				14
15	Catch basin			2000	1,029		10				15
16	Sewer ejector pump repairs			2001	3,194		10				16
17	Sewer ejector pump repairs			2001	2,556		10				17
18	Replacement of hot water systems			2001	11,840		20				18
19	Replacement of hot water systems			2001	11,840		20				19
20	Asbestos removal from boiler			2001	10,156		10				20
21	HVAC			2001	1,523		10				21
22	Carpet			2001	804		7				22
23	HVAC			2001	1,395		10				23
24	Valve			2001	798		10				24
25	Hot water system			2001	11,840		20				25
26	Hot water tank			2001	3,013		20				26
27	Refrigeration lines			2001	1,094		10				27
28	Electrical			2001	3,529		10				28
29	Boiler pipe			2001	1,748		10				29
30	Expansion study			2001	15,503		20				30
31	Voice cables			2001	747		10				31
32	Professional services			2002	9,129		15				32
33	Wreck building			2002	8,804		15				33
34	Antenna			2002	3,917		10				34
35	Circulating pump			2003	2,111		10				35
36	Receivers			2003	18,090		5				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 Benedict Nursing & Rehab # 0044784 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

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	Condensing unit	2003	$ 4,167	$	15	$	$	$	37
38	Conduits	2003	2,676		20				38
39	Fire alarm	2001	423		7				39
40	Fire alarm	2001	1,811		7				40
41	Door	2002	603		10				41
42	Pump	2002	989		10				42
43	Power lines	2002	603		10				43
44	Pump catch basin	2002	563		10				44
45	Swing door	2002	708		10				45
46	Fire protection	2002	1,811		7				46
47	Air conditioning	2002	812		10				47
48	Air conditioning	2002	451		10				48
49	Refrigerator ball valves	2002	717		10				49
50	Air conditioning	2002	714		10				50
51	Air conditioning	2002	1,356		10				51
52	Refrigerator ball valves	2002	1,104		10				52
53	Freezer	2002	1,817		10				53
54	Valve	2002	564		10				54
55	Condensor motor	2002	1,162		5				55
56	Compressor	2002	515		10				56
57	Fire protection	2002	1,811		7				57
58	Pump system	2002	1,805		10				58
59	Fire protection	2003	1,811		7				59
60	Fire protection	2003	1,811		7				60
61	Circulating pump	2003	1,401		10				61
62	Fire protection	2003	1,811		7				62
63	Air station	2003	1,897		10				63
64	Fire protection	2003	1,884		7				64
65	Data wiring	2003	804		10				65
66	Hot water circulation pump	2003	860		10				66
67	Fire alarm system power supply	2003	1,433		10				67
68	Boiler tubes	2003	7,312		10				68
69	Pump rayback boiler	2003	1,109		10				69
70	TOTAL (lines 4 thru 69)		$ 4,496,439	$		$	$	$	70

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

Facility Name & ID Number St Benedict Nursing & Rehab # 0044784 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

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		$ 4,496,439	$		$	$	$	1
2	AO Smith 40 gallon	2003	638		10				2
3	Century high ambient motor	2003	781		5				3
4	Boiler repairs	2003	808		10				4
5	Fire protection	2003	2,161		7				5
6	Air compressor	2003	695		5				6
7	Side stream filter system	2003	4,575		10				7
8	Tamper re-wiring	2004	1,296		10				8
9	Air pump handler	2004	1,069		10				9
10	Fire protection	2004	2,161		7				10
11	Exhaust fan	2004	1,158		10				11
12	Fire protection	2004	2,161		7				12
13	Wiring & cabling	2004	641		10				13
14									14
15	Landscaping additions, tree removal, new trees, etc.	2005	8,500		5-15				15
16	Concrete sidewalk	2005	3,600		12				16
17	Reseal & restripe parking lot	2005	6,910						17
18	Roof replacement	2005	104,735		15				18
19	Repair & update east elevator	2005	3,187		10				19
20	Refractory for boiler	2005	3,765		10				20
21	Fire-safe shutoff valve	2005	1,310		8				21
22	Care-watch system	2005	2,075		5				22
23	Von Duprin controls wiring	2005	1,800		8				23
24	Install egress exits systems on 2nd floor	2005	14,540		15				24
25	Carpet	2005	11,946		5				25
26	One-man Genie gated lift	2005	7,565		15				26
27	Fire equipment	2005	1,027		15				27
28	Repair & replace pumps	2005	19,495		15				28
29									29
30	Replace limestone on sign	2006	1,800		15				30
31	Replace valve & actuator, repipe bad piping	2006	2,032		15				31
32	Carpet	2006	12,624		10				32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,721,494	$		$	$	$	34

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

Facility Name & ID Number St Benedict Nursing & Rehab # 0044784 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

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		$ 4,721,494	$		$	$	$	1
2	Replace 4" check valve on sump pump	2006	1,674		8				2
3	Replace power supply for main fire alarm system	2006	3,645		10				3
4	Repair/Replace waste stack for kitchen sink	2006	1,688		10				4
5	Carpeting for resident rooms	2006	10,890		10				5
6	2" x 3/4" pipe replacement	2006	3,645		15				6
7	Carpeting for Chapel	2006	3,184		10				7
8	Lowering of Tabernacle	2006	288		5				8
9									9
10	Cable wiring activities	2006	2,228	149	15	149		446	10
11	Install cable 1st & 2nd floor nurse station	2006	5,791	386	15	386		1,158	11
12	Carpet for apartments	2006	10,495	1,499	7	1,499		4,496	12
13	Chair	2006	14,946	996	15	996		2,988	13
14	Carpet for dining room	2006	9,947	1,421	7	1,421		4,264	14
15	Washer	2006	1,708	244	7	244		732	15
16	Carpet for chapel	2006	1,997	285	7	285		856	16
17	Analog station module, cable	2006	1,376	172	8	172		516	17
18	Platinum 5 LX oxygen concentrator	2006	6,385	912	7	912		2,736	18
19	Alternating pressure pad suntech	2006	8,550	1,221	7	1,221		3,662	19
20	Custom bedside wood edge, dresser	2007	4,613	308	15	308		1,078	20
21	All purpose riser bed	2007	13,331	1,333	10	1,333		4,667	21
22	Install new cooling coil	2006	16,195	2,314	7	2,314		6,678	22
23	Install new heater for dish machine	2006	2,138	305	7	305		916	23
24	Test and certify Model 709 fire	2006	1,770	253	7	253		758	24
25	Remove and install new 200 gal storage tank	2007	11,345	1,621	7	1,621		5,672	25
26	55-60 lb. Washer	2007	16,780	2,098	8	2,098		7,343	26
27	Clean out cracked sealer around roof	2007	2,115	264	8	264		924	27
28	Sofa & loveseat	2007	2,103	140	15	140		490	28
29	Roof shingles	2007	1,950	195	10	195		684	29
30	Ejector pump in boiler room	2007	5,664	708	8	708		2,478	30
31	Engineering services	2007	2,259	323	7	323		1,129	31
32	Install new gasketed fresh air damper for kitchen	2006	4,611	659	7	659		1,976	32
33	Single deck convection oven	2007	8,798	1,100	8	1,100		3,850	33
34	TOTAL (lines 1 thru 33)		$ 4,903,603	$ 18,906		$ 18,906	$	$ 60,497	34

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

Facility Name & ID Number St Benedict Nursing & Rehab # 0044784 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

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		$ 4,903,603	$ 18,906		$ 18,906	$	$ 60,497	1
2	Fire alarm door system upgrade	2007	1526	153	10	153		382	2
3	Fire alarm door system upgrade	2008	29,855	2,986	10	2,986		7,465	3
4	Install 3 phones in Elevator	2007	4,650	465	10	465		1,163	4
5	New motor for East Elevator	2008	9,047	905	10	905		2,262	5
6	Upgrade to boiler system	2007	11,408	1,901	6	1,901		4,710	6
7	Upgrade to boiler system	2008	15,778	1,434	11	1,434		3,586	7
8	Exhaust Mods, Permits, Bonds, Drawings	2007	16,092	3,218	5	3,218		8,045	8
9	Repair Injector pump	2007	8,305	554	15	554		1,385	9
10	Installation of Jeron EC-210 Duty Station	2008	2,650	265	10	265		663	10
11	Display& Accessories	2010	450	75	3	75		75	11
12	Computer	2010	1,504	251	3	251		251	12
13	Beds & Bumpers	2010	12,412	414	15	414		414	13
14	Flaker/Dispenser	2010	3,278	164	10	164		164	14
15	Lighting retrofit	2010	7,612	381	10	381		381	15
16	Code alert wander system	2010	11,561	826	7	826		826	16
17	Valve replacement	2010	8,079	404	10	404		404	17
18	CMS Response	2010	7,341	367	10	367		367	18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28	Financial statement depreciation			196,621		196,621		2,186,502	28
29	Allocated from Home Office					63,238	63,238		29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,055,151	$ 230,290		$ 293,528	$ 63,238	$ 2,279,542	34

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

Facility Name & ID Number St Benedict Nursing & Rehab # 0044784 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

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	$ 1,013,744	$ 43,060	$ 43,060	$	5 to 10	$ 706,304	71
72	Current Year Purchases	52,237	2,881	2,881		5 to 15	2,881	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,065,981	$ 45,941	$ 45,941	$		$ 709,185	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				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	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)	$ 9,278,322	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 276,231	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 339,469	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 63,238	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,988,727	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	Depreciable non-care assets	$ 1,095,075	$ 45,675	$ 541,336	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 1,095,075	$ 45,675	$ 541,336	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	$	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 Benedict Nursing & Rehab # 0044784 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$		N/A	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.	/2011	$
13.	/2012	$
14.	/2013	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 3,941 Description: Copiers, $ 3,941
    (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 Benedict Nursing & Rehab # 0044784 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

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 Benedict Nursing & Rehab # 0044784 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service		Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A(1,3)	1719	hrs	$ 66,760	1,745	$ 103,884	$	3,464	$ 170,644	1
2	Licensed Speech and Language Development Therapist	10A(1,3)	499	hrs	25,657				499	25,657	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10A(1,3)	3282	hrs	147,486	146	9,089		3,428	156,575	4
5	Physician Care			visits							5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy	39(2)		# of prescrpts				703,463		703,463	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				$ 239,903	1,891	$ 112,973	$ 703,463	7,391	$ 1,056,339	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 Benedict Nursing & Rehab **#** 0044784 **Report Period Beginning:** 7/1/2009 **Ending:** 6/30/2010

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/2010 **(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	$ 562,992	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 320,587)	409,261		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	5,289		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)**	$ 977,542	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	7,268,881		12
13	Land	2,910,262		13
14	Buildings, at Historical Cost	5,926,802		14
15	Leasehold Improvements, at Historical Cost	49,995		15
16	Equipment, at Historical Cost	1,565,926		16
17	Accumulated Depreciation (book methods)	(2,988,727)		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)**	$ 14,733,139	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 15,710,681	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ (1,152,005)	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			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				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ (1,152,005)	$	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)**	$ (1,152,005)	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 16,862,686	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 15,710,681	$	48

***(See instructions.)**

Facility Name & ID Number St Benedict Nursing & Rehab # 0044784 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 15,167,552	1
2	Restatements (describe):		2
3	**Prior Period adjustments**	(16,826)	3
4	**equity transfers**	32,709	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 15,183,435	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,679,251	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)**	$ 1,679,251	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)**	$ 16,862,686	24 *

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

Facility Name & ID Number St Benedict Nursing & Rehab # 0044784 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

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	$ 9,522,074	1
2	Discounts and Allowances for all Levels	(1,963,348)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,558,726	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,635,331	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,635,331	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		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	6,583	14
15	Telephone, Television and Radio	2,988	15
16	Rental of Facility Space	27,808	16
17	Sale of Drugs	907,475	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	16,945	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	17,976	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 979,775	23
	D. Non-Operating Revenue		
24	Contributions	470,356	24
25	Interest and Other Investment Income***	298,435	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 768,791	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	22,666	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 22,666	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,965,289	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,659,511	31
32	Health Care	3,138,364	32
33	General Administration	3,086,964	33
	B. Capital Expense		
34	Ownership	345,125	34
	C. Ancillary Expense		
35	Special Cost Centers	718,837	35
36	Provider Participation Fee	54,203	36
	D. Other Expenses (specify):		
37	Assisted Living Expenses	105,583	37
38	Provision for Uncollectable Accounts	177,451	38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,286,038	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,679,251	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,679,251	43

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? yes 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.**

St. Benedict Nursing & Rehabilitation Center
Provider # 0044784
7/1/2009 - 6/30/2010

Schedule 19A

XVII - Income Statement: Line 22 - Laundry

NOTE: Laundry revenue is generated from charges to private pay residents located in the facility, therefore it has not been offset against related expenses.

Line 28: Other Revenue

Description	
ADMI - OTHER REVENUE	22,666
Total	22,666

Facility Name & ID Number St Benedict Nursing & Rehab # 0044784 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

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	1,740	2,080	$ 95,002	$ 45.67	1
2	Assistant Director of Nursing					2
3	Registered Nurses	19,447	22,101	774,063	35.02	3
4	Licensed Practical Nurses	8,127	9,358	261,426	27.94	4
5	CNAs & Orderlies	69,750	78,202	1,067,325	13.65	5
6	CNA Trainees					6
7	Licensed Therapist	5,160	5,500	239,903	43.62	7
8	Rehab/Therapy Aides	4,501	5,216	121,030	23.20	8
9	Activity Director					9
10	Activity Assistants	6,919	7,625	112,025	14.69	10
11	Social Service Workers	1,924	2,080	56,738	27.28	11
12	Dietician	952	1,040	35,042	33.69	12
13	Food Service Supervisor	1,800	2,040	58,539	28.70	13
14	Head Cook	8,271	9,334	129,130	13.83	14
15	Cook Helpers/Assistants	16,944	19,351	197,278	10.19	15
16	Dishwashers					16
17	Maintenance Workers	4,484	5,135	110,071	21.44	17
18	Housekeepers	14,382	16,120	175,218	10.87	18
19	Laundry	9,502	10,644	113,418	10.66	19
20	Administrator					20
21	Assistant Administrator	1,968	2,080	69,481	33.40	21
22	Other Administrative	7,412	8,338	127,653	15.31	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)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: Plan Cooord	2,503	2,736	106,953	39.09	32
33	Other(specify) See Page 20a	13,590	14,951	230,612	15.42	33
34	TOTAL (lines 1 - 33)	199,376	223,931	$ 4,080,907 *	$ 18.22	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	18,504	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 18,504		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

St. Benedict Nursing & Rehabilitation Center
Provider # 0044784
7/1/2009 - 6/30/2010

Schedule 20A

	Hours Worked	Hours Paid	Wages	Ave. Hrly. Wage
XVIII - Salary & Wages - Line 32 Other Health Care				
Religious wages	5,473	5,699	121,794	21.37
Assisted Living	8,117	9,252	108,818	11.76
Total	13,590	14,951	230,612	15.42

Facility Name & ID Number St Benedict Nursing & Rehab # 0044784 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Peter Goschy	Administrator	0	$ 69,480
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 69,480

B. Administrative - Other

Description	Amount
Management Fees	$
(Eliminated on Sch. V, Line 17, Col. 3)	1,060,142
TOTAL (agree to Schedule V, line 17, col. 3)	$ 1,060,142
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
N/A		$
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 44,732
Unemployment Compensation Insurance	25,741
FICA Taxes	293,369
Employee Health Insurance	863,643
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Life Insurance	8,477
Employee Disability Insurance	28,795
Employee Dental Insurance	20,398
Employee Retirement	404,472
Employee Morale & Other Benefits	21,993
Allocated From Home Office	63,897
Disallowed Assisted Living Costs	(124,764)
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,650,753

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

Description	Line #	Amount
N/A		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
Life Services Network of Illinois dues	2,622
Illinois Council on Long Term Care	1,530
Miscellaneous Dues & Subscriptions	1,457
IDPA Dues	995
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 6,604

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
See Attached	1,852
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,852

**See instructions.

St. Benedict Nursing & Rehabilitation Center
Provider # 0044784
7/1/2009 - 6/30/2010

Schedule 21A

XIX - Support Schedules Item G. Seminar Expense

Sum of Amount Name	Total
BACZKURA,	360
SMITH,LIN	13
GREENSPHA	267
MARATHON	1,212
Grand Total	1,852

Facility Name & ID Number St Benedict Nursing & Rehab # 0044784 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

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	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number St Benedict Nursing & Rehab # 0044784 **Report Period Beginning:** 7/1/2009 **Ending:** 6/30/2010

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? **Yes**
If YES, give association name and amount. **LSN $2622, ICLTC $1530**

(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? **12.5 yrs.**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **13,490** Line **10(2)**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **54,203**
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? **Yes-Assisted Living** 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. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **6,583**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **Adequate records are maintained.**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **0**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **KPMG 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? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.