

Facility Name & ID Number St Clara's Manor

0050724 Report Period Beginning: 1-01-10 Ending: 12-31-10

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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	140	Skilled (SNF)	140	51,100	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	140	TOTALS	140	51,100	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	21,828	13,258	4,589	39,675	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	21,828	13,258	4,589	39,675	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.64%

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

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

none

F. Does the facility maintain a daily midnight census?

yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 1970

J. Was the facility purchased or leased after January 1, 1978?

YES Date _____ NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified _____ and days of care provided 4,589

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: _____ Fiscal Year: _____

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

Facility Name & ID Number

St Clara's Manor

0050724

Report Period Beginning:

1-01-10

Ending:

12-31-10

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	300,057	35,867		335,924		335,924		335,924		1
2	Food Purchase		260,027		260,027		260,027		260,027		2
3	Housekeeping	147,338	18,233		165,571		165,571		165,571		3
4	Laundry	52,562	8,656		61,218		61,218		61,218		4
5	Heat and Other Utilities			137,080	137,080		137,080		137,080		5
6	Maintenance	61,868	65,382	63,280	190,530		190,530		190,530		6
7	Other (specify):*										7
8	TOTAL General Services	561,825	388,165	200,360	1,150,350		1,150,350		1,150,350		8
	B. Health Care and Programs										
9	Medical Director			600	600		600		600		9
10	Nursing and Medical Records	1,879,598	164,328	16,131	2,060,057		2,060,057		2,060,057		10
10a	Therapy		174,666	691,805	866,471	(238,150)	628,321		628,321		10a
11	Activities	65,083	2,993		68,076		68,076		68,076		11
12	Social Services	37,747	128	3,233	41,108		41,108		41,108		12
13	CNA Training		1,000		1,000		1,000		1,000		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,982,428	343,115	711,769	3,037,312	(238,150)	2,799,162		2,799,162		16
	C. General Administration										
17	Administrative	70,562			70,562		70,562		70,562		17
18	Directors Fees										18
19	Professional Services			356,555	356,555		356,555	(2,488)	354,067		19
20	Dues, Fees, Subscriptions & Promotions			117,330	117,330	(76,650)	40,680	(21,807)	18,873		20
21	Clerical & General Office Expenses	119,429	27,580	9,030	156,039		156,039		156,039		21
22	Employee Benefits & Payroll Taxes			729,727	729,727		729,727		729,727		22
23	Inservice Training & Education			3,987	3,987		3,987	(1,988)	1,999		23
24	Travel and Seminar			1,560	1,560		1,560		1,560		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			100,289	100,289		100,289		100,289		26
27	Other (specify):*			39,049	39,049		39,049	(38,770)	279		27
28	TOTAL General Administration	189,991	27,580	1,357,527	1,575,098	(76,650)	1,498,448	(65,053)	1,433,395		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,734,244	758,860	2,269,656	5,762,760	(314,800)	5,447,960	(65,053)	5,382,907		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 Clara's Manor

#0050724

Report Period Beginning:

1-01-10

Ending:

12-31-10

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation											30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			459,900	459,900		459,900		459,900			34
35	Rent-Equipment & Vehicles			986	986		986		986			35
36	Other (specify):*											36
37	TOTAL Ownership			460,886	460,886		460,886		460,886			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					238,150	238,150		238,150			39
40	Barber and Beauty Shops			17,870	17,870		17,870		17,870			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					76,650	76,650		76,650			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			17,870	17,870	314,800	332,670		332,670			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,734,244	758,860	2,748,412	6,241,516		6,241,516	(65,053)	6,176,463			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 Clara's Manor

0050724

Report Period Beginning:

1-01-10

Ending:

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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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer-ence	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		35		5
6	Rented Facility Space		34		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation		30		9
10	Interest and Other Investment Income		32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions		33		15
16	Personal Expenses (Including Transportation)	(1,988)	23		16
17	Non-Care Related Fees		20		17
18	Fines and Penalties				18
19	Entertainment		24		19
20	Contributions	(29,770)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(2,488)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(9,000)	27		24
25	Fund Raising, Advertising and Promotional	(21,807)	20		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)	\$ (65,053)		\$	30

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	2	
		Amount	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 (A) and (B)	\$ (65,053)		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	2	3	4	
		Yes	No	Amount	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

BHF USE ONLY							
48		49		50		51	

St Clara's Manor

ID# 0050724

Report Period Beginning: 1-01-10

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Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1		\$		1
2				2
3				3
4				4
5		0	35	5
6		0	34	6
7				7
8				8
9		0	30	9
10			32	10
11				11
12				12
13		0	2	13
14			32	14
15		0	33	15
16			24	16
17		0	20	17
18				18
19			24	19
20		(29,770)	27	20
21				21
22		(2,488)	19	22
23				23
24		(9,000)	27	24
25		(21,807)	20	25
26				26
27				27
28				28
29		0	33	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	(63,065)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number St Clara's Manor

0050724

Report Period Beginning:

1-01-10

Ending:

12-31-10

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	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(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	(2,488)	0	0	0	0	0	0	0	0	0	0	(2,488)	19
20	Fees, Subscriptions & Promotions	(21,807)	0	0	0	0	0	0	0	0	0	0	(21,807)	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	(1,988)	0	0	0	0	0	0	0	0	0	0	(1,988)	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):*	(38,770)	0	0	0	0	0	0	0	0	0	0	(38,770)	27
28	TOTAL General Administration	(65,053)	0	0	0	0	0	0	0	0	0	0	(65,053)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(65,053)	0	0	0	0	0	0	0	0	0	0	(65,053)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number St Clara's Manor

0050724

Report Period Beginning:

1-01-10

Ending:

12-31-10

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

	Capital Expense	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)
	D. Ownership												
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0 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	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	0	0	0	0	0	0	0	0	0	0	0	0 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)	(65,053)	0	0	0	0	0	0	0	0	0	0	(65,053) 45

Facility Name & ID Number

St Clara's Manor

0050724

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1-01-10

Ending:

12-31-10

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
None						

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. 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	4	5 Cost to Related Organization	6	7	8 Difference:	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V		\$				\$	1
2	V				0.00%			2
3	V							3
4	V				0.00%			4
5	V							5
6	V				0.00%			6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$				\$ *	14

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

Facility Name & ID Number

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1-01-10

Ending:

12-31-10

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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	attached								\$		1
2											2
3									0	line 18	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

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1-01-10

Ending: 12-31-10

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

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

Name of Related Organization Heritage Operations Group
 Street Address box 3188
 City / State / Zip Code Bloomington, IL 61701
 Phone Number ()
 Fax Number ()

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	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 St Clara's Manor

0050724

Report Period Beginning:

1-01-10

Ending:

12-31-10

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		8	9	10									
					Name of Lender	Related**				Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
						YES							NO	Original				Balance
A. Directly Facility Related																		
Long-Term																		
1						\$				\$								
2																		
3																		
4																		
5																		
Working Capital																		
6																		
7																		
8																		
9	TOTAL Facility Related					\$	\$			\$								
B. Non-Facility Related*																		
10	Interest Income																	
11	Allocated Corporate																	
12																		
13																		
14	TOTAL Non-Facility Related					\$	\$			\$								
15	TOTALS (line 9+line14)					\$	\$			\$								

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.)

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2009 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 St Clara's Manor COUNTY Logan

FACILITY IDPH LICENSE NUMBER 0050724

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)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
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 St Clara's Manor

0050724

Report Period Beginning:

1-01-10

Ending:

12-31-10

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 53,286 B. General Construction Type: Exterior brick Frame wood Number of Stories 1

C. Does the Operating Entity? (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? (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).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES 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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$ 38,660	1
2					2
3	TOTALS			\$ 38,660	3

Facility Name & ID Number St Clara's Manor

0050724

Report Period Beginning:

1-01-10

Ending:

12-31-10

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	140				\$ 1,624,882	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	1976		1976		65,361						9
10	1978		1978		3,451						10
11	1980		1980		8,793						11
12	1981		1981		11,439						12
13	1982		1982		3,826						13
14	1983		1983		1,535						14
15	1984		1984		4,031						15
16	1985		1985		7,859						16
17	1986		1986		2,541						17
18	1987		1987		10,753						18
19	1988		1988		1,006						19
20	1989		1989		1,431						20
21	1991		1991		8,799						21
22	1992		1992		17,963						22
23	1993		1993		15,564						23
24	1994		1994		51,022						24
25	1995		1995		124,932						25
26	1996		1996		102,380						26
27	1997		1997		39,247						27
28	Fire Sprinkler		1998		22,151						28
29	Transfer Switch		1998		4,819						29
30	Water Line		1998		6,379						30
31	Soffits		1998		3,950						31
32	Generator		1998		3,164						32
33	Heating, A/C Improvements		1998		8,664						33
34	C/O Allocation										34
35	Book Depreciation										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 St Clara's Manor# 0050724

Report Period Beginning:

1-01-10

Ending:

12-31-10**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Windows	1998	\$ 3,422	\$		\$	\$	37
38	Sidewalks	1998	2,963					38
39	Fixtures	1999	224					39
40	Faucets	1999	1,532					40
41	Water System Improvements	1999	7,920					41
42	Windows	1999	23,400					42
43	Fixtures	1999	2,812					43
44	Faucets	1999	1,404					44
45	Heating & Cooling Unit	2000	4,050					45
46	Water System	2000	37,203					46
47	Glass Doors	2000	1,145					47
48	Remodeling	2000	4,581					48
49	Plumbing	2000	4,128					49
50	Windows	2000	600					50
51	Plumbing	2000	1,702					51
52	4 Ton Condensing Unit	2000	4,453					52
53	Windows	2000	5,400					53
54	Exhaust Fan	2000	1,100					54
55	Heating & Cooling Units	2000	4,050					55
56	Doors	2000	4,081					56
57	Porch Ceiling	2000	4,050					57
58	Exhaust Fan	2000	2,046					58
59	Concrete Pad	2000	5,398					59
60	Fire Sprinkler	2001	1,304					60
61	Faucets	2001	3,432					61
62	Patio Roof	2001	1,532					62
63	Exhaust Fan	2001	1,000					63
64	A/C Unit	2001	16,312					64
65	A/C Kitchen	2001	6,850					65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)		\$ 2,314,036	\$		\$	\$	70

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

Facility Name & ID Number St Clara's Manor

0050724

Report Period Beginning:

1-01-10

Ending:

12-31-10

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 2,314,036	\$		\$	\$	\$	1
2								2
3	2002	5,600						3
4	2002	996						4
5	2002	4,550						5
6	2002	2,361						6
7	2002	3,342						7
8	2002	17,518						8
9	2002	92,577						9
10	2002	824						10
11	2002	3,167						11
12								12
13	2003	53,524						13
14	2003	11,041						14
15	2003	33,616						15
16	2003	4,188						16
17	2003	38,929						17
18	2003	(10,796)						18
19	2004	1,800						19
20	2004	2,624						20
21	2004	8,094						21
22	2004	2,955						22
23	2004	1,598						23
24	2004	2,350						24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34		\$ 2,594,894	\$		\$	\$	\$	34

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

Facility Name & ID Number St Clara's Manor

0050724

Report Period Beginning:

1-01-10

Ending:

12-31-10

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	3	4	5	6	7	8	9
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
1		\$ 2,594,894	\$		\$	\$	\$
2							
3	2005	726					
4	2005	1,662					
5	2005	2,543					
6	2005	20,919					
7	2005	1,187					
8	2005	1,845					
9							
10	2006	1,843					
11	2006	1,059					
12	2006	1,287					
13	2006	1,207					
14							
15							
16							
17	2008	8,105					
18							
19	2008	183,160					
20	2008	18,587					
21							
22	2009	4,477					
23							
24	2010	11,260					
25							
26							
27							
28							
29							
30							
31							
32							
33							
34		\$ 2,854,761	\$		\$	\$	\$

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 2,854,761	\$		\$	\$	\$	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	TOTAL (lines 1 thru 33)	\$ 2,854,761	\$		\$	\$	\$	34

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

Facility Name & ID Number St Clara's Manor

0050724

Report Period Beginning:

1-01-10

Ending:

12-31-10

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	\$ 1,220,698	\$	\$	\$		\$	71
72	Current Year Purchases	3,847						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,224,545	\$	\$	\$		\$	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)	\$ 4,117,966	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$	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.

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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies		1,000		1,000
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	\$	\$ 1,000	\$	\$ 1,000
10	SUM OF line 9, col. 1 and 2 (e)	\$	1,000		

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.

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

	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	\$		\$ 225,507	\$		\$ 225,507	1
2	Licensed Speech and Language Development Therapist		hrs			69,274			69,274	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			332,790	750		333,540	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts				173,916		173,916	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					64,234			64,234	13
14	TOTAL			\$		\$ 691,805	\$ 174,666		\$ 866,471	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 St Clara's Manor

0050724

Report Period Beginning: 1-01-10

Ending:

12-31-10

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12-31-10

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,555,577	\$	1
2	Cash-Patient Deposits	38,177		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	274,254		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	41,999		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	257,820		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,167,827	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)			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)	\$	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,167,827	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 247,746	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	38,177		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	215,400		30
31	Accrued Taxes Payable (excluding real estate taxes)	1,737		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)	\$ 503,060	\$	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)	\$ 503,060	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 1,664,767	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,167,827	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,252,405	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,252,405	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	412,362	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)	\$ 412,362	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,664,767	24 *

* This must agree with page 17, line 47.

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.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 6,411,315	1
2	Discounts and Allowances for all Levels	(2,307,077)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,104,238	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,207,014	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,207,014	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	1,212	12
13	Barber and Beauty Care	21,417	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	311,071	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	4,075	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 337,775	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	4,851	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 4,851	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Other		28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,653,878	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,150,350	31
32	Health Care	3,037,312	32
33	General Administration	1,575,098	33
B. Capital Expense			
34	Ownership	460,886	34
C. Ancillary Expense			
35	Special Cost Centers	17,870	35
36	Provider Participation Fee		36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,241,516	40
41	Income before Income Taxes (line 30 minus line 40)**	412,362	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 412,362	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 St Clara's Manor

0050724

Report Period Beginning:

1-01-10

Ending:

12-31-10

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,952	2,120	\$ 73,519	\$ 34.68	1
2	Assistant Director of Nursing	2,016	2,124	73,040	34.39	2
3	Registered Nurses	3,931	4,130	91,528	22.16	3
4	Licensed Practical Nurses	27,748	29,624	619,881	20.92	4
5	CNAs & Orderlies	82,408	87,876	970,930	11.05	5
6	CNA Trainees			0		6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,340	2,452	50,700	20.68	8
9	Activity Director					9
10	Activity Assistants	5,835	6,295	65,083	10.34	10
11	Social Service Workers	1,963	2,138	37,747	17.66	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	31,261	33,410	300,057	8.98	15
16	Dishwashers					16
17	Maintenance Workers	5,671	6,157	61,868	10.05	17
18	Housekeepers	13,749	5,820	147,338	25.32	18
19	Laundry	5,045	5,671	52,562	9.27	19
20	Administrator	1,900	2,080	70,562	33.92	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,243	6,933	119,429	17.23	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	192,062	196,830	\$ 2,734,244 *	\$ 13.89	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	\$ 0		35
36	Medical Director	600		36
37	Medical Records Consultant	9,576		37
38	Nurse Consultant			38
39	Pharmacist Consultant	4,895		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	3,233		45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 18,304		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	0	\$ 0	50
51	Licensed Practical Nurses	0	0	51
52	Certified Nurse Assistants/Aides	0	0	52
53	TOTAL (lines 50 - 52)		\$	53

Facility Name & ID Number St Clara's Manor

Report Period Beginning: 1-01-10 Ending: 12-31-10

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	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	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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. Illinois Health Care Association
- (3) Did the nursing home make political contributions or payments to a political action organization? no If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? no If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? yes
What was the average life used for new equipment added during this period? 7yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 5,000 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. _____
- (9) Are you presently operating under a sublease agreement? _____ YES xx 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. \$ 76,650
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 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. \$ 166
- (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. \$ _____
 - 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? yes
 - g. Does the facility transport residents to and from day training? no**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? yes
Firm Name: Abbot & Co
- (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.