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: 0044370

Facility Name: St Francis Nursing & Rehab Center

Address: 500 Asbury Street (Number) Evanston (City) 60202 (Zip Code)

County: Cook

Telephone Number: (847) 316-3320 **Fax #** (847) 316-3337

HFS ID Number:

Date of Initial License for Current Owners: 03/08/85

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 07/01/2009 to 06/30/2010 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 Francis Nursing & Rehab Center # 0044370 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

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	124	Skilled (SNF)	124	45,260	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	124	TOTALS	124	45,260	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	23,227	2,874	7,565	33,666	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	23,227	2,874	7,565	33,666	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.38%

D. How many bed-hold days during this year were paid by the Department?
N/A (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 [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 03/08/85

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 03/08/85 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 124 and days of care provided

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 06/30/10 Fiscal Year: 06/30/10

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

Facility Name & ID Number St Francis Nursing & Rehab Center # 0044370 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

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	326,084	53,487	8,321	387,892		387,892	(6,775)	381,117			1
2	Food Purchase		213,527		213,527		213,527		213,527			2
3	Housekeeping	170,498	29,327	6,485	206,310		206,310		206,310			3
4	Laundry		171,102	996	172,098		172,098	(1,024)	171,074			4
5	Heat and Other Utilities			108,984	108,984		108,984		108,984			5
6	Maintenance	47,000	9,493	122,256	178,749		178,749		178,749			6
7	Other (specify):*											7
8	**TOTAL General Services**	543,582	476,936	247,042	1,267,560		1,267,560	(7,799)	1,259,761			8
	B. Health Care and Programs											
9	Medical Director			22,034	22,034		22,034		22,034			9
10	Nursing and Medical Records	2,379,267	119,641	26,240	2,525,148		2,525,148		2,525,148			10
10a	Therapy	346,175	2,549	55,261	403,985		403,985		403,985			10a
11	Activities	123,811	13,326	20,631	157,768		157,768		157,768			11
12	Social Services	61,903	133	2,839	64,875		64,875		64,875			12
13	CNA Training											13
14	Program Transportation			13,640	13,640		13,640		13,640			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,911,156	135,649	140,645	3,187,450		3,187,450		3,187,450			16
	C. General Administration											
17	Administrative	104,164		833,065	937,229		937,229	(833,065)	104,164			17
18	Directors Fees											18
19	Professional Services			1,033	1,033		1,033		1,033			19
20	Dues, Fees, Subscriptions & Promotions			7,030	7,030		7,030		7,030			20
21	Clerical & General Office Expenses	286,346	33,797	(25,137)	295,006		295,006	586,396	881,402			21
22	Employee Benefits & Payroll Taxes			1,455,960	1,455,960		1,455,960	60,544	1,516,504			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,034	2,034		2,034		2,034			24
25	Other Admin. Staff Transportation			2,631	2,631		2,631		2,631			25
26	Insurance-Prop.Liab.Malpractice			203,342	203,342		203,342		203,342			26
27	Other (specify):*											27
28	**TOTAL General Administration**	390,510	33,797	2,479,958	2,904,265		2,904,265	(186,125)	2,718,140			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,845,248	646,382	2,867,645	7,359,275		7,359,275	(193,924)	7,165,351			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 Francis Nursing & Rehab Center #0044370 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

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			337,498	337,498		337,498	75,869	413,367			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			84,175	84,175		84,175	(68,038)	16,137			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			68,746	68,746		68,746		68,746			35
36	Other (specify):*											36
37	**TOTAL Ownership**			490,419	490,419		490,419	7,831	498,250			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		737,335		737,335		737,335		737,335			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			67,890	67,890		67,890		67,890			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		737,335	67,890	805,225		805,225		805,225			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,845,248	1,383,717	3,425,954	8,654,919		8,654,919	(186,093)	8,468,826			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 Francis Nursing & Rehab Center # 0044370 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

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	(6,775)	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	(1,024)	4		8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				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	(947)	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 see pg 5A	(5,464)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (14,210)		$	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))**	$ (14,210)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

St Francis Nursing & Rehab Center

ID# 0044370

Report Period Beginning: 07/01/2009

Ending: 06/30/2010

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Misc Revenue	$ (5,464)	21	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(5,464)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number St Francis Nursing & Rehab Center **#** 0044370 **Report Period Beginning:** 07/01/2009 **Ending:** 06/30/2010

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 TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	(6,775)	0	0	0	0	0	0	0	0	0	0	(6,775)	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	(1,024)	0	0	0	0	0	0	0	0	0	0	(1,024)	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**	(7,799)	0	0	0	0	0	0	0	0	0	0	(7,799)	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	(833,065)	0	0	0	0	0	0	0	0	0	(833,065)	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	(6,411)	592,807	0	0	0	0	0	0	0	0	0	586,396	21
22	Employee Benefits & Payroll Taxes	0	60,544	0	0	0	0	0	0	0	0	0	60,544	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**	(6,411)	(179,714)	0	0	0	0	0	0	0	0	0	(186,125)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(14,210)	(179,714)	0	0	0	0	0	0	0	0	0	(193,924)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number St Francis Nursing & Rehab Center # 0044370 **Report Period Beginning:** 07/01/2009 **Ending:** 06/30/2010

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	0	75,869	0	0	0	0	0	0	0	0	0	75,869	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	(68,038)	0	0	0	0	0	0	0	0	0	(68,038)	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	7,831	0	0	0	0	0	0	0	0	0	7,831	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)**	(14,210)	(171,883)	0	0	0	0	0	0	0	0	0	(186,093)	45

Facility Name & ID Number St Francis Nursing & Rehab Center # 0044370 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

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
	100	See Attached		See Attached		
Resurrection Health Care						

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 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%	$ 592,807	$ 592,807	1
2	V	22	Employee benefits		Resurrection Health Care	100.00%	60,544	60,544	2
3	V	30	Depreciation		Resurrection Health Care	100.00%	75,869	75,869	3
4	V	32	Interest	84,175	Resurrection Health Care	100.00%	16,137	(68,038)	4
5	V								5
6	V								6
7	V	17	Intercompany Expense	833,065	Resurrection Health Care	100.00%		(833,065)	7
8	V	39	Intercompany Pharmacy	737,335	Resurrection Health Care	100.00%	737,335		8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,654,575			$ 1,482,692	$ * (171,883)	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 Francis Nursing & Rehab Center # 0044370 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

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 Francis Nursing & Rehab Center # 0044370 Report Period Beginning: 07/01/2009 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 ☐ 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				$	$		$ 592,807	1
2	22	Employee benefits							60,544	2
3	30	Depreciation							75,869	3
4	32	Interest							16,137	4
5										5
6										6
7										7
8	39	Intercompany Pharmacy							737,335	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					$	$		$ 1,482,692	25

Facility Name & ID Number St Francis Nursing & Rehab Center # 0044370 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

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												10
11								Allocated from Home Office			16,137	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 16,137	14
15	TOTALS (line 9+line14)						$	$			$ 16,137	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 Francis Nursing & Rehab Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0044370

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 and does not pay 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 _____ 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 Francis Nursing & Rehab Center **#** 0044370 **Report Period Beginning:** 07/01/2009 **Ending:** 06/30/2010

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 and does not pay 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 Francis Nursing & Rehab Center # 0044370 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 51,712 B. General Construction Type: Exterior Brick Frame _____ Number of Stories _____

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. [x] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care	51,712	1985	$ 188,421	1
2					2
3	TOTALS	51,712		$ 188,421	3

Facility Name & ID Number St Francis Nursing & Rehab Center # 0044370 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

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	124		1985	1961	$ 2,426,118	$ 80,660	30	$ 80,660	$	$ 2,063,153	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	General Construction/Renovation			1986	12,875		12			12,875	9
10	General Construction/Renovation			1986	3,543		10			3,543	10
11	General Construction/Renovation			1986	82,489		15			82,489	11
12	General Construction/Renovation			1986	44,717		20			44,717	12
13	General Construction/Renovation			1987	5,529		12			5,529	13
14	General Construction/Renovation			1987	2,560		10			2,560	14
15	Inhouse Labor			1988	7,688		5			7,688	15
16	Shower			1989	3,836	95	20	95		3,931	16
17	Lobby Refurbish/Exterior Renovation			1991	73,428		5			73,428	17
18	Dishwasher and Installation			1991	7,332		10			7,332	18
19	Sidewalk Replacement			1991	4,880		5			4,880	19
20	Remodel			1993	30,862		15			30,862	20
21	Vestibule: Wallpaper/Painting; Window Draperies			1996	4,601	307	15	307		4,296	21
22	Combustion Air Handling System			1996	24,969		10			24,969	22
23	Fire Alarm System			1996	71,668		10			71,668	23
24	Parking Lot Repaving			1997	7,162	477	15	477		6,224	24
25	Roofing: Drain flashing collar;coping replacement										25
26	deck repair; masonry repointing; install new drains			1997	74,400	4,960	15	4,960		64,687	26
27	Admin offices: carpeting; wallpapering & painting;										27
28	electrical wiring and lighting			1997	12,270	818	15	818		10,668	28
29	Renovate 3 Nursing Floors: painting & wallpapering;										29
30	install ADA handles & mirrors; carpeting & floor										30
31	tiling; installation of glass blocks & window										31
32	masonry; installation and modification of light										32
33	fixtures; plumbing & H.V.A.C. sprinklers			1997	499,653	33,310	15	33,310		434,419	33
34	Security Camera System			1997	16,014		10			16,014	34
35	Parking Lot Repaving			1999	8,530	569	15	569		6,542	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 Francis Nursing & Rehab Center # 0044370 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

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	Day Room Expansion & Renovation: tear down wall		$	$		$	$	$	37
38	between day room & conference room to expand day								38
39	room; install new ceiling & ceiling tiles; new flooring;								39
40	wallpaper & painting; install cupboard & sink; revamp								40
41	closet; window treatment	1999	23,212		10			23,212	41
42	Remove & replace all windows on 1st, 2nd, & 3rd floors	1999	118,907	7,927	15	7,927		91,161	42
43	Acquisition and installation of sternberg lights	2000	7,400	493	15	493		5,178	43
44	Fire dampers/automatic closers	2000	21,493	1,433	15	1,433		15,046	44
45	Vonsuperior Panic Hardware for 9 doors	2000	8,058		7			8,058	45
46	Demolition of existing entrance, waiting area and								46
47	chapel entrance; install flooring, automatic door system,								47
48	anodized store front thermal glazed window system,								48
49	ceiling tile system w/lighting, and wall covering;								49
50	relocate chapel entrance; new concrete sidewalks								50
51	and accessibility ramp.	2000	190,424	9,523	10	9,523		190,424	51
52	Relocate portable fire extinguishers with casing &								52
53	vinyl wallcovering	2001	4,606		5			4,606	53
54	Acquisition/installation exterior concrete bench	2001	2,674		5			2,674	54
55	Acquisition/installation 54"X114" plate glass								55
56	for dayroom	2001	1,350		7			1,350	56
57	Refinish & apply slip grips 36 bathtubs	2001	9,720		5			9,720	57
58	PT/OT renovation: demolition of 2 block walls, casework								58
59	and flooring; install new cabinets; new folding partition;								59
60	new drywall partition; new VCT flooring; paint and vinyl								60
61	wallcovering; plumbing for sinks 7 sprinklers	2001	56,042	5,604	10	5,604		53,239	61
62	Parking lot expansion	2002	536,437	34,878	15	34,878		296,482	62
63	Elevator alarm system	2002	30,000		7			30,000	63
64	Building security system	2002	21,710		7			21,710	64
65	Solar shades/awning & installation	2002	5,084		7			5,084	65
66	Window air conditioners & installation	2002	10,439		5			10,439	66
67	IDPH safety code compliance - includes but not limited to:								67
68	protection of lay-in fixtures and equipment;								68
69	automatic door closures tied into fire alarm system which (continued on P12B)								69
70	TOTAL (lines 4 thru 69)		$ 4,472,680	$ 181,054		$ 181,054	$	$ 3,750,857	70

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

Facility Name & ID Number St Francis Nursing & Rehab Center # 0044370 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

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		$ 4,472,680	$ 181,054		$ 181,054	$	$ 3,750,857	1
2	is activated by smoke detectors, pull stations and sprinkler								2
3	system; installation of smoke operated fire dampers and								3
4	access panels in exhaust duct system penetrating smoke								4
5	barrier walls located on floors 1, 2 and 3.	2002	481,852	46,597	10	46,597		396,074	5
6	Interior renovation - includes but not limited to:								6
7	Toli floor and ramp; carpet administration area; switch-								7
8	bank for lobby and entrance area; new light fixtures in								8
9	various area; replace piping to boilers; new condensing								9
10	unit to north window well; reheat coil in lobby; replace								10
11	bathroom fixtures; replace/upgrade ceiling in various areas;								11
12	various wall modifications; replace various bathroom								12
13	fixtures; various other electrical and plumbing								13
14	modifications.	2002	159,709	16,549	10	16,549		140,668	14
15	Exterior renovation - includes not limited to: sliding doors;								15
16	removal and replacement of concrete curbs; paving,								16
17	grading and stonework; install new fire ceiling and framing								17
18	in smoking area; new handicap signs; various electrical								18
19	work in outside waiting area (includes new heaters,								19
20	intercom and doorbell).	2002	98,000	6,533	15	6,533		55,531	20
21	Lobby renovation - includes but not limited to: selective								21
22	demolition of existing lobby, toilet room, and reception								22
23	and replacement of each as well as new assisted bathing.								23
24	this includes new partitions, electric plumbing, HVAC,								24
25	acoustic panel ceiling, floor finishes, doors, frames,								25
26	interior windows and casement. Floral fixtures and								26
27	artwork.	2002	166,549	11,732	14	11,732		99,723	27
28	Acquisition/installation of medical records voice and data								28
29	cables, 24-port patch panel, and fire stop & sleeves	2003	4,646	310	15	310		2,325	29
30	2 sewage pumps	2003	5,752	383	15	383		2,873	30
31	Down light style fixtures-acquisition and electrical work	2003	3,780	252	15	252		1,890	31
32	Elevator control valve piping	2003	10,037	1,004	10	1,004		7,530	32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,403,005	$ 264,414		$ 264,414	$	$ 4,457,471	34

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

Facility Name & ID Number St Francis Nursing & Rehab Center # 0044370 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

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		$ 5,403,005	$ 264,414		$ 264,414	$	$ 4,457,471	1
2	Remove existing and install new nurse station (1st floor)	2004	8,300	553	15	553		3,555	2
3	Purchase & install quarry tile in kitchen entrance	2004	1,114	111	5	111		1,225	3
4	Grout kitchen floor	2004	4,740	474	10	474		3,081	4
5	Purchase & install raised round rubber tiles in elevator	2004	1,538		5			1,538	5
6	Purchase & install 2 ceiling 40-gallon ASME coded								6
7	expansion tanks	2004	3,685		5			3,685	7
8	Purchase & install hot water heater	2004	3,250	216	15	216		1,404	8
9	Purchase & install category 5E wire cable in elevator	2004	758	76	10	76		494	9
10	Replace wood floor with concrete in oxygen storage closet	2004	1,750	116	15	116		754	10
11									11
12	Carpet for lobby and chapel	2005	4,730	955	5	955		3,260	12
13	Overhead domestic water line	2005	1,075	108	10	108		369	13
14	Replace main drain & rod sewer	2005	3,052	203	15	203		694	14
15	Elevator upgrade	2005	6,184	618	10	618		2,109	15
16	Lever drains in three compartment sinks	2005	1,744	174	10	174		592	16
17	Baxtor Flo Guard Pump	2005	5,973	597	10	597		2,191	17
18									18
19	Phase 2 Fireman's Recall	2006	59,921	3,995	15	3,995		17,802	19
20	Upgrade electrical feed for reznor roof top unit	2006	12,950	1,295	10	1,295		5,828	20
21	Replace sprinkler heads in kitchen	2006	2,137	214	10	214		214,749	21
22	Replace ceiling tiles in kitchen	2006	2,300	153	15	153		689	22
23	Mixer bench gear drive 20qt.	2006	3,820	255	15	255		1,147	23
24	Vulcan Range 60" burner 20" griddle gas type	2006	3,945	395	10	395		1,777	24
25	Replace window & glaze	2006	4,765	318	15	318		1,431	25
26	Combination Lennox make up air unit	2006	15,000	1,500	10	1,500		6,750	26
27	50 pair cable to north & south wings	2006	4,617	308	15	308		1,386	27
28	Relays, transformers & t-stats on boiler	2006	2,500	250	10	250		1,125	28
29	Elevator upgrade	2006	14,625	1,462	10	1,462		6,579	29
30									30
31	Replace Concrete	2006	7,100	473	15	473		1,656	31
32	Furnish & Install Fire Rated Wood Doors	2006	2,741	182	15	182		637	32
33	Furnish & Install New Door in Receiving Area	2006	4,230	202	15	202		747	33
34	TOTAL (lines 1 thru 33)		$ 5,591,549	$ 279,617		$ 279,617	$	$ 4,744,725	34

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

Facility Name & ID Number St Francis Nursing & Rehab Center # 0044370 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

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		$ 5,591,549	$ 279,617		$ 279,617	$	$ 4,744,725	1
2	Inspect & Install 3 Fire Dampers & 3 Access Panels	2006	5,049	505	10	505		1,767	2
3	Remove & Replace tile around sink & paint ceiling in rooms 303 &	2007	3,958	440	9	440		1,540	3
4	Install 6" RPZ valve on fire sprinkler system	2006	7,000	700	10	700		2,450	4
5	Replace Sprinkler Heads on Floors 1, 2 & 3	2007	3,439	491	7	491		1,719	5
6	Replace voice cable on 3rd Floor	2007	14,994	2,142	7	2,142		7,497	6
7	35 American Standard - Madera	2007	6,475	926	7	926		3,241	7
8	Electrical work	2007	6,885	861	8	861		3,013	8
9	Ceiling Tile Toilet Repair Kits	2007	12,400	1,550		1,550		5,425	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	allocated from Home Office					75,869	75,869		29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,651,749	$ 287,232		$ 363,101	$ 75,869	$ 4,771,377	34

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

Facility Name & ID Number St Francis Nursing & Rehab Center # 0044370 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

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	$ 1,101,338	$ 49,967	$ 49,967	$	5-15	$ 520,903	71
72	Current Year Purchases	5,971	299	299		10	299	72
73	Fully Depreciated Assets	816,547					816,547	73
74								74
75	TOTALS	$ 1,923,856	$ 50,266	$ 50,266	$		$ 1,337,749	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)	$ 7,764,026	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 337,498	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 413,367	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 75,869	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 6,109,126	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	N/A				88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

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

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

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

Facility Name & ID Number St Francis Nursing & Rehab Center # 0044370 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

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:				$			3
4	Additions							4
5					N/A			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: $ 68,746 Description: Specialized Beds 63,865 Copiers 4,881
(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			N/A		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 Francis Nursing & Rehab Center # 0044370 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

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 Francis Nursing & Rehab Center # 0044370 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

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(1,2,3)	2749	hrs	$ 104,761	470	$ 26,491	$	3,219	$ 131,252	1
2	Licensed Speech and Language Development Therapist	10A(1,2,3)	529	hrs	19,859				529	19,859	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10A(1,2,3)	6566	hrs	216,199	478	26,699		7,044	242,898	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				737,335		737,335	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				$ 340,819	948	$ 53,190	$ 737,335	10,792	$ 1,131,344	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 Francis Nursing & Rehab Center # 0044370 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/2010 (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	$ 53,139	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 334,518)	833,595		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	6,263		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)**	$ 892,997	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	5,180,943		14
15	Leasehold Improvements, at Historical Cost	449,988		15
16	Equipment, at Historical Cost	1,944,675		16
17	Accumulated Depreciation (book methods)	(6,109,127)		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)**	$ 1,466,479	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,359,476	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 11,414,249	$	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)**	$ 11,414,249	$	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)**	$ 11,414,249	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (9,054,773)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,359,476	$	48

*(See instructions.)

Facility Name & ID Number St Francis Nursing & Rehab Center # 0044370 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (7,496,031)	1
2	Restatements (describe):		2
3	**Prior Period Adjustment**	(14,194)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (7,510,225)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,544,548)	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)**	$ (1,544,548)	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)**	$ (9,054,773)	24 *

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

Facility Name & ID Number St Francis Nursing & Rehab Center # 0044370 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

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	$ 8,539,137	1
2	Discounts and Allowances for all Levels	(3,288,824)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,250,313	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,208,971	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,208,971	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	6,775	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	950,265	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	14,177	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	1,023	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 972,240	23
	D. Non-Operating Revenue		
24	Contributions	50	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 50	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	5,464	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 5,464	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,437,038	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,267,560	31
32	Health Care	3,173,810	32
33	General Administration	2,917,905	33
	B. Capital Expense		
34	Ownership	490,419	34
	C. Ancillary Expense		
35	Special Cost Centers	737,335	35
36	Provider Participation Fee	67,890	36
	D. Other Expenses (specify):		
37	Provision for uncollectable accounts	326,667	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,981,586	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,544,548)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,544,548)	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 Francis Nursing & Rehab Center # 0044370 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

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	1,840	2,080	$ 90,176	$ 43.35	1
2	Assistant Director of Nursing					2
3	Registered Nurses	28,677	33,313	1,237,686	37.15	3
4	Licensed Practical Nurses	5,978	6,750	182,807	27.08	4
5	CNAs & Orderlies	54,941	62,437	802,604	12.85	5
6	CNA Trainees					6
7	Licensed Therapist	8,814	9,844	340,820	34.62	7
8	Rehab/Therapy Aides	4,090	4,602	71,935	15.63	8
9	Activity Director					9
10	Activity Assistants	5,136	5,893	79,538	13.50	10
11	Social Service Workers	2,406	2,804	65,148	23.23	11
12	Dietician	2	2	45	22.50	12
13	Food Service Supervisor	3,540	4,158	85,275	20.51	13
14	Head Cook	7,501	8,279	116,083	14.02	14
15	Cook Helpers/Assistants	10,271	11,683	127,375	10.90	15
16	Dishwashers					16
17	Maintenance Workers	1,851	2,096	46,800	22.33	17
18	Housekeepers	12,949	14,939	169,371	11.34	18
19	Laundry					19
20	Administrator	1,872	2,080	104,164	50.08	20
21	Assistant Administrator					21
22	Other Administrative	8,846	9,885	165,797	16.77	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: Care Plan Coord	2,998	3,377	116,301	34.44	32
33	Other(specify) Religious Wages	1,502	1,655	43,323	26.18	33
34	TOTAL (lines 1 - 33)	163,214	185,877	$ 3,845,248 *	$ 20.69	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	22,034	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)		$ 22,034		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	93	$ 4,355	10(3)	50
51	Licensed Practical Nurses	88	3,464	10(3)	51
52	Certified Nurse Assistants/Aides	38	870	10(3)	52
53	TOTAL (lines 50 - 52)	219	$ 8,689		53

Facility Name & ID Number St Francis Nursing & Rehab Center # 0044370 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Michael Kaplan	Administrator	0	$ 104,164
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 104,164

B. Administrative - Other

Description	Amount
Management Fees (eliminated in column 7)	$ 833,065
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 833,065

C. Professional Services

Vendor/Payee	Type	Amount
Joseph Pieper	Legal	1,033
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 1,033

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 35,188
Unemployment Compensation Insurance	21,786
FICA Taxes	277,738
Employee Health Insurance	738,754
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Life Insurance	7,152
Disability	24,248
Retirement	330,252
Employee Morale/Recognition	18,504
Home Office Allocaiton	60,544
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,514,166

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

Description	Line #	Amount
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 975
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
Life Services Network & AAHSA dues	
city of Evanston	4,020
Miscellaneous Dues & Subcriptions	2,035
Illinois Council on Long-term Care dues	
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 7,030

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,631
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,631

**See instructions.

Facility Name & ID Number St Francis Nursing & Rehab Center # 0044370 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

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

Facility Name & ID Number St Francis Nursing & Rehab Center # 0044370 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

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. **City of Evanston 4020- ; misc 2035**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7.5 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **11,260** 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?
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. $ **67,890**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **6,775**

(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. $ **N/A**

(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.