		FOR BHF USE					

LL1

2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0044784

Facility Name: St. Benedict Nursing & Rehab Center

Address: 6930 West Touhy Avenue (Number) Niles (City) 60174 (Zip Code)

County: Cook

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

HFS ID Number:

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

Type of Ownership:

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

IRS Exemption Code 501(c)(3)

In the event there are further questions about this report, please contact:
Name: Patrick Szajkovics, SR, Inc. **Telephone Number:** (630) 530-7100, Ext. 111
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/01/2010 to 6/30/2011 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) 10/28/2011 (Date)
(Type or Print Name) Nicola Byrne
(Title) Vice President, Finance

Paid Preparer

(Signed) 10/28/2011 (Date)
(Print Name and Title) Patrick Szajkovics, Senior Consultant
(Firm Name & Address) Strategic Reimbursement, Inc., 360 W. Butterfield Road, Suite 310, Elmhurst, IL 60126
(Telephone) (630) 530-7100 Fax # (630) 530-7106

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number St. Benedict Nursing & Rehab Center # 0044784 Report Period Beginning: 7/01/2010 Ending: 6/30/2011

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	99	Skilled (SNF)	99	36,135	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	99	TOTALS	99	36,135	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	3,160	7,887	12,236	23,283	8
9	SNF/PED					9
10	ICF	2,265	7,173	883	10,321	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	5,425	15,060	13,119	33,604	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.00%

D. How many bed-hold days during this year were paid by the Department?
O (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 99 and days of care provided 10,057

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: 6/30/2011 Fiscal Year: 6/30/2011

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

Facility Name & ID Number St. Benedict Nursing & Rehab Center # 0044784 Report Period Beginning: 7/01/2010 Ending: 6/30/2011

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

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	417,372		83,632	501,004		501,004	(151,885)	349,119			1
2	Food Purchase		285,422		285,422		285,422	(85,464)	199,958			2
3	Housekeeping	206,608			206,608		206,608	(61,864)	144,744			3
4	Laundry	131,476	55,202		186,678		186,678	(11,170)	175,508			4
5	Heat and Other Utilities			215,926	215,926		215,926	(65,654)	150,272			5
6	Maintenance	121,062	5,061	150,898	277,021		277,021	(82,948)	194,073			6
7	Other (specify):*											7
8	**TOTAL General Services**	876,518	345,685	450,456	1,672,659		1,672,659	(458,985)	1,213,674			8
	B. Health Care and Programs											
9	Medical Director			18,504	18,504		18,504		18,504			9
10	Nursing and Medical Records	2,306,938	132,760	83,715	2,523,413		2,523,413		2,523,413			10
10a	Therapy	527,521	777	42,234	570,532		570,532		570,532			10a
11	Activities	147,045	15,446		162,491		162,491		162,491			11
12	Social Services	125,287	14,103	3,100	142,490		142,490		142,490			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,106,791	163,086	147,553	3,417,430		3,417,430		3,417,430			16
	C. General Administration											
17	Administrative	86,931		960,744	1,047,675		1,047,675		1,047,675			17
18	Directors Fees											18
19	Professional Services											19
20	Dues, Fees, Subscriptions & Promotions			8,152	8,152		8,152		8,152			20
21	Clerical & General Office Expenses	380,031	11,293	(3,727)	387,597		387,597	11,336	398,933			21
22	Employee Benefits & Payroll Taxes			1,528,910	1,528,910		1,528,910	(125,101)	1,403,809			22
23	Inservice Training & Education											23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			112,739	112,739		112,739		112,739			26
27	Other (specify):*											27
28	**TOTAL General Administration**	466,962	11,293	2,606,818	3,085,073		3,085,073	(113,765)	2,971,308			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,450,271	520,064	3,204,827	8,175,162		8,175,162	(572,750)	7,602,412			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification

Facility Name & ID Number St. Benedict Nursing & Rehab Center #0044784 Report Period Beginning: 7/01/2010 Ending: 6/30/2011

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			456,513	456,513		456,513	(44,229)	412,284			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			100,059	100,059		100,059	(100,059)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			11,919	11,919		11,919		11,919			35
36	Other (specify):*											36
37	TOTAL Ownership			568,491	568,491		568,491	(144,288)	424,203			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			740,574	740,574		740,574		740,574			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			54,203	54,203		54,203		54,203			42
43	Other (specify):* Assistd/Ind Livng	110,745		27,386	138,131		138,131	(138,131)				43
44	TOTAL Special Cost Centers	110,745		822,163	932,908		932,908	(138,131)	794,777			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,561,016	520,064	4,595,481	9,676,561		9,676,561	(855,169)	8,821,392			45

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

Facility Name & ID Number St. Benedict Nursing & Rehab Center # 0044784 Report Period Beginning: 7/01/2010 Ending: 6/30/2011

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	(1,870)	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	(11,170)	4		8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(100,059)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotiona	(11,396)	21		25
26	Income Taxes and Illinois Persona Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule Page 5A	(730,674)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (855,169)		$	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 Organizatio 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))**	$ (855,169)		37

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

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

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

St. Benedict Nursing & Rehab Center

ID# 0044784

Report Period Beginning: 7/01/2010

Ending: 6/30/2011

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Misc. Income	$ (22,868)	21	1
2	Offset Assisted / Indep Living Wages & Other Exp.	(138,131)	43	2
3	Offset Empl benefits for Assisted / Indep Living	(125,101)	22	3
4	Offset Dietary costs for Assisted / Indep Living	(150,015)	1	4
5	Offset Food costs for Assisted / Indep Living	(85,464)	2	5
6	Offset Housekeeping for Assisted / Indep Living	(61,864)	3	6
7	Offset Utilities Exp for Assisted / Indep Living	(65,654)	5	7
8	Offset Maintenance for Assisted / Indep Living	(82,948)	6	8
9	Offset Depreciation for Assisted / Indep Living	(44,229)	30	9
10	Offset Charity Care exp. Credit adjustment from Hospital	45,600	21	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**	(730,674)		49

STATE OF ILLINOIS **Summary A**

Facility Name & ID Number St. Benedict Nursing & Rehab Center **#** 0044784 **Report Period Beginning:** 7/01/2010 **Ending:** 6/30/2011

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	(151,885)	0	0	0	0	0	0	0	0	0	0	(151,885)	1
2	Food Purchase	(85,464)	0	0	0	0	0	0	0	0	0	0	(85,464)	2
3	Housekeeping	(61,864)	0	0	0	0	0	0	0	0	0	0	(61,864)	3
4	Laundry	(11,170)	0	0	0	0	0	0	0	0	0	0	(11,170)	4
5	Heat and Other Utilities	(65,654)	0	0	0	0	0	0	0	0	0	0	(65,654)	5
6	Maintenance	(82,948)	0	0	0	0	0	0	0	0	0	0	(82,948)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(458,985)	0	0	0	0	0	0	0	0	0	0	(458,985)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	11,336	0	0	0	0	0	0	0	0	0	0	11,336	21
22	Employee Benefits & Payroll Taxes	(125,101)	0	0	0	0	0	0	0	0	0	0	(125,101)	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**	(113,765)	0	0	0	0	0	0	0	0	0	0	(113,765)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(572,750)	0	0	0	0	0	0	0	0	0	0	(572,750)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number St. Benedict Nursing & Rehab Center # 0044784 **Report Period Beginning:** 7/01/2010 **Ending:** 6/30/2011

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	(44,229)	0	0	0	0	0	0	0	0	0	0	(44,229)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(100,059)	0	0	0	0	0	0	0	0	0	0	(100,059)	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**	(144,288)	0	0	0	0	0	0	0	0	0	0	(144,288)	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):*	(138,131)	0	0	0	0	0	0	0	0	0	0	(138,131)	43
44	**TOTAL Special Cost Centers**	(138,131)	0	0	0	0	0	0	0	0	0	0	(138,131)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(855,169)	0	0	0	0	0	0	0	0	0	0	(855,169)	45

Facility Name & ID Number St. Benedict Nursing & Rehab Center # 0044784 Report Period Beginning: 7/01/2010 Ending: 6/30/2011

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Resurrection Health Care	100	See Attached		See Attached		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ 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%	$	$	1
2	V	22	Employee benefits		Resurrection Health Care	100.00%			2
3	V	30	Depreciation	156,841	Resurrection Health Care	100.00%	156,841		3
4	V	32	Interest	100,059	Resurrection Health Care	100.00%	100,059		4
5	V								5
6	V								6
7	V	17	Intercompany expense	960,744	Resurrection Health Care	100.00%	960,744		7
8	V	39	Intercompany pharmacy	740,574	Resurrection Health Care	100.00%	740,574		8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,958,218			$ 1,958,218	$ *	14

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

Resurrection Nursing & Rehab Center
Schedule for Form 990
Page 5, Part VI, Line 80b
Related Organizations
Twelve Months Ending June 30, 2011

Related Organizations	Fed Tax ID No	Tax Status
Holy Family Health Care Systems, Inc.	36-3495969	Exempt
Holy Family Medical Center	36-2439318	Exempt
L. Gilbraith Insurance SPC Ltd.		Non-Exempt
Our Lady of Resurrection Medical Center	36-2644178	Exempt
Proviso Family Services, Inc. - DBA Resurrection Behavioral Health	36-2709982	Exempt
Resurrection Ambulatory Services	36-4286236	Exempt
Resurrection Development Foundation	36-3330929	Exempt
Resurrection Health Care Corporation	36-2235165	Exempt
Resurrection Health Care Preferred, Inc.	36-3974620	Non-Exempt
Resurrection Home Health Services	36-2893936	Exempt
Resurrection Medical Center	36-3330926	Exempt
Resurrection Ministries of New York	14-1720818	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

Facility Name & ID Number St. Benedict Nursing & Rehab Center # 0044784 Report Period Beginning: 7/01/2010 Ending: 6/30/2011

VII. RELATED PARTIES

A. (Continued) **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions**

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	See 6A Attached		See 6A Attached		See 6A Attached			1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number St. Benedict Nursing & Rehab Center # 0044784 Report Period Beginning: 7/01/2010 Ending: 6/30/2011

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 and 7B								$		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

RESURRECTION HEALTH CARE CORPORATION
BOARD OF DIRECTORS
October, 2010

	OFFICE
Mr. Thomas D. Settles Chairperson	1424 West Old Bay Road Johnsburg, IL 60051 847/925-1300 (FAX 847/214-6012) tsettles@pcec.net
Ms. Sandra Bruce, FACHE	President & CEO Resurrection Health Care 7435 West Talcott Avenue Chicago, IL 60631 773-792-5555 (FAX 773-990-8601) Email: sbruc01@reshealthcare.org
Janis Atkinson, M.D.	Saint Francis Hospital 355 Ridge Avenue Evanston, IL 60201 Cell: (847) 502-5800 Home: (847) 256-0932 FAX: (847) 316-2943 E-Mail: jatkinson@reshealthcare.org
Mr. Kenneth Bauwens	Co-President Jamerson & Bauwens Electric Co. 3055 MacArthur Boulevard Northbrook, Illinois 60062 847/291-2000 (FAX 847/291-2008) kbauwens@jbelectric.com
Haven Cockerham	President & CEO Cockerham & Associates LLC 10130 Mallard Creek Road Suite 300

	Charlotte, NC 28262 704-944-5520 (Charlotte Office- Audra Miller) 312-253-4037 (Chicago office) Email: Haven@cockerhamassociates.com Email assistant: audra@cockerhamassociates.com
Michael D. Connelly	President & CEO Catholic Healthcare Partners 615 Elsinore Place Cincinnati, OH 45202 513/639-2809 (FAX 513/639-2804) Email: mdconnelly@health-partners.org Assistant's email: cmross@health-partners.org
Anthony DeFuric	Vice President and CFO University of Colorado Hospital P.O. Box 6510, Mail Stop F417 Aurora, CO 80045-6510 720/848-7816 (FAX 720-848-5542) Email: Anthony.defurio@uch.edu Via FedEX: University of Colorado Hospital Leprino Building, 10th floor 12401 E. 17th Avenue, #1043 Aurora, CO 80045
Sister Loretta Theresa Felici, C.S.F.N	4001 Grant Avenue Philadelphia, PA 19114-2999 215/268-1035 Email: ltfelici@aol.com
Stephen Klasko, M.D.	17717 Gulf Blvd. #701 Redington Shores, FL 33708 813-760-5642 –cell (FAX 813-974-4207) Email: sklasko2@gmail.com

Sister Patricia Ann Koschalke, C.S.F.N	Chairperson Sponsorship Board Holy Family Medical Cente 150 North River Road, Ste. 210 847/813-3451 (FAX: 847/813-3482) Email: pkoschalke@reshealthcare.org
Susan McDonough	Vice President, Strategy & System Development Covenant Health Systems, Inc 100 Ames Pond Drive, Suite 102 Tewksbury, MA 01876 978/654-6363 (FAX: 978/851-0828) Susan_mcdonough@covenanths.org Linda_donaghue@covenanths.org (assistant)
Victor Orler	121 west 9th street Hinsdale, IL 60521 630/654-0615 (FAX 630/654-2030) Email: Vic@Orler. Net
Jeffrey M. Silver, M.D.	7447 West Talcott Avenue Suite 512 Chicago, IL 60631 847/788-1553 (FAX 773-577-8187) DJsilver@msn.com
Mr. Chester Stewart	703 N. East Avenue Oak Park, IL 60302 708/383-7167 Email: clstewy@aol.com
James Winikates	619 Keystone Avenue River Forest, IL 60305-1613 708-771-9371 (voice and fax) Email: jwinikates@comcast.ne
Sister Donna Marie Wolowicki, C.R	Executive Vice President/CEC

Resurrection Medical Center
7435 West Talcott Avenue
Chicago, Illinois 60631
773/792-5153 (FAX 773/792-9926)
Email: sdonna@reshealthcare.org

OFFICERS
EFFECTIVE AS OF SEPTEMBER 30, 2010

TITLE	NAME
Executive Vice President/CEO, Continuum Care Services	John Baird
Vice President	Peter Goschy
Treasurer	John Orsini
Assistant Treasurer	Nicola Byrne
Secretary	Jeannie C. Frey
Assistant Secretary	John Walton

Facility Name & ID Number St. Benedict Nursing & Rehab Center # 0044784 Report Period Beginning: 7/01/2010 Ending: 6/30/2011

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	21	Clerical & data processing	(Per Medicare HO CR)	1	1	$ 960,744	$	1	$ 960,744	1
2	22	Employee benefits	(Per Medicare HO CR)							2
3	30	Depreciation	(Per Medicare HO CR)	1	1	156,841		1	156,841	3
4	32	Interest Expense	(Per Medicare HO CR)	1	1	100,059		1	100,059	4
5										5
6	39	Intercompany Pharmacy		1	1	740,574		1	740,574	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					$ 1,958,218	$		$ 1,958,218	25

Facility Name & ID Number St. Benedict Nursing & Rehab Center # 0044784 Report Period Beginning: 7/01/2010 Ending: 6/30/2011

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	Allocated from Home Office						$	$			$ 100,059	1
2												2
3												3
4												4
5												5
	Working Capital											
6	N/A											6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 100,059	9
	B. Non-Facility Related*											
10	Interest Income Offset										(100,059)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (100,059)	14
15	TOTALS (line 9+line14)						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number St. Benedict Nursing & Rehab Center # 0044784 **Report Period Beginning:** 7/01/2010 **Ending:** 6/30/2011

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 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 2011 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 (		$	7

Real Estate Tax History

Real Estate Tax Bill for Calendar Year			
	2006		8
	2007		9
	2008		10
	2009		11
	2010		12

Facility is a not-for-profit and does not pay real estate taxes for the LTC main property.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2010	$	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.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME St. Benedict Nursing & Rehab Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0044784

CONTACT PERSON REGARDING THIS REPORT Thomas W. Groenwald

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

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

Enter the tax index number and real estate tax assessed for 2010 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 2010.

	(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 taxes for the LTC main property.		$	$
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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number St. Benedict Nursing & Rehab Center # 0044784 Report Period Beginning: 7/01/2010 Ending: 6/30/2011

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

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

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

Independent Living Units

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

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

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	LTC Facility	56,961	2000	$ 2,910,262	1
2					2
3	TOTALS	56,961		$ 2,910,262	3

Facility Name & ID Number St. Benedict Nursing & Rehab Center # 0044784 Report Period Beginning: 7/01/2010 Ending: 6/30/2011

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	99		2000	1991	$ 4,247,413	$ 108,840	35	$ 108,840	$	$ 1,145,207	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2000	30,917	488	7 - 10	488		30,917	9
10	Various			2001	273,061	17,637	7 - 20	17,637		177,716	10
11	Various			2002	34,410	2,371	10 - 20	2,371		22,041	11
12	Various			2003	3,328	166	20	166		1,414	12
13	Various			2004	14,267	828	10 - 20	828		6,098	13
14	Various			2005	190,455	13,510	5 - 15	13,510		104,836	14
15	Various			2006	83,605	8,209	5 - 15	8,209		41,010	15
16											16
17	Various			2007	110,939	14,381	5 - 15	14,381		58,381	17
18											18
19	Fire alarm door system upgrade			2008	29,855	2,986	10	2,986		10,451	19
20	New motor for East Elevator			2008	9,047	905	10	905		3,167	20
21	Upgrade to boiler system			2008	15,778	1,434	11	1,434		5,020	21
22	Installation of Jeron EC-210 Duty Station			2008	2,650	265	10	265		928	22
23											23
24	Display& Accessories			2010	450	150	3	150		225	24
25	Computer			2010	1,504	501	3	501		752	25
26	Beds & Bumpers			2010	12,412	827	15	827		1,241	26
27	Flaker/Dispenser			2010	3,278	328	10	328		492	27
28	Lighting retrofit			2010	7,612	761	10	761		1,142	28
29	Code alert wander system			2010	11,561	1,652	7	1,652		2,478	29
30	Valve replacement			2010	8,079	808	10	808		1,212	30
31	St. Bens CMS (Emergency) Response system			2010	7,341	734	10	734		1,101	31
32											32
33											33
34											34
35											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. Benedict Nursing & Rehab Center # 0044784 Report Period Beginning: 7/01/2010 Ending: 6/30/2011

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66	Financial Statement Depreciation Adjustment		2	(1,423)		(1,423)		(1)	66
67	Home office allocation					156,841	156,841		67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 5,097,964	$ 176,358		$ 333,199	$ 156,841	$ 1,615,828	70

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

Facility Name & ID Number St. Benedict Nursing & Rehab Center # 0044784 Report Period Beginning: 7/01/2010 Ending: 6/30/2011

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,406,717	$ 62,943	$ 62,943	$	3 - 20	$ 1,010,271	71
72	Current Year Purchases	288,414	16,142	16,142		3 - 20	16,142	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,695,131	$ 79,085	$ 79,085	$		$ 1,026,413	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 9,703,357	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 255,443	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 412,284	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 156,841	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,642,241	85	

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Depreciable Non Care Assets	$ 1,098,056	$ 44,229	$ 587,056	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 1,098,056	$ 44,229	$ 587,056	91

G. Construction-in-Progress

	Description	Cost	
92	TB Accrual (CIP)	$ 8,565	92
93			93
94			94
95		$ 8,565	95

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

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

Facility Name & ID Number St. Benedict Nursing & Rehab Center # 0044784 Report Period Beginning: 7/01/2010 Ending: 6/30/2011

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	N/A			$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

10. Effective dates of current rental agreement:
Beginning _____
Ending _____

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

	Fiscal Year Ending	Annual Rent
12.	/2012	$
13.	/2013	$
14.	/2014	$

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: $ 11,919 Description: Copiers and Medical Equipment (See Schedule)
(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	N/A		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

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

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

Provider Number: 0044784

FYE: 6/30/2011

Attachment to Schedule XII, Line 16- Equipment Rental Cost

Sub Acct 7020

Equipment	Amount
Copier	4,591
Medical Equipment	7,328
Total Equipment Lease Exp	11,919

Facility Name & ID Number St. Benedict Nursing & Rehab Center # 0044784 Report Period Beginning: 7/01/2010 Ending: 6/30/2011

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.

Any CNAs hired were already trained.

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.

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

	Service	1 Schedule V Line & Column Reference	2 Staff Units of Service	3 Staff Cost	4 Outside Practitioner (other than consultant) Units	5 Outside Practitioner Cost	6 Supplies (Actual or) Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A (1 & 3)	2616 hrs	$ 102,823	559	$ 34,672	$	3,175	$ 137,495	1
2	Licensed Speech and Language Development Therapist	10A (1 & 3)	1270 hrs	62,976				1,270	62,976	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A (1 & 3)	3508 hrs	158,809	128	7,185		3,636	165,994	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				740,574		740,574	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			$ 324,608	687	$ 41,857	$ 740,574	8,081	$ 1,107,039	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number St. Benedict Nursing & Rehab Center # 0044784 **Report Period Beginning:** 7/01/2010 **Ending:** 6/30/2011

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 6/30/2011 (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	$ 443,036	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 117,439)	701,854		3
4	Supply Inventory (priced a)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	3,852		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,148,742	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	7,639,795		12
13	Land	2,910,262		13
14	Buildings, at Historical Cost	5,926,802		14
15	Leasehold Improvements, at Historical Cos	49,995		15
16	Equipment, at Historical Cost	1,922,919		16
17	Accumulated Depreciation (book methods)	(3,229,298)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	61,140		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(59,102)		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)**	$ 15,222,513	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 16,371,255	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 46,614	$	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	Due to RMC	(2,519,033)		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ (2,472,419)	$	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)**	$ (2,472,419)	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 18,843,675	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 16,371,256	$	48

***(See instructions.)**

Facility Name & ID Number St. Benedict Nursing & Rehab Center # 0044784 Report Period Beginning: 7/01/2010 Ending: 6/30/2011

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 16,862,687	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 16,862,687	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,980,988	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)**	$ 1,980,988	17
	B. Transfers (Itemize):		
18			18
19	**Net Assets Released to Equity**		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)**	$ 18,843,675	24 *

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

Facility Name & ID Number St. Benedict Nursing & Rehab Center # 0044784 Report Period Beginning: 7/01/2010 Ending: 6/30/2011

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 9,935,808	1
2	Discounts and Allowances for all Level	(980,026)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,955,782	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,285,154	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,285,154	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	1,870	14
15	Telephone, Television and Radio	3,875	15
16	Rental of Facility Space	18,387	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	11,170	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 35,302	23
	D. Non-Operating Revenue		
24	Contributions	3,650	24
25	Interest and Other Investment Income***	358,668	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 362,318	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc Income	18,993	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 18,993	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 11,657,549	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,672,659	31
32	Health Care	3,417,430	32
33	General Administration	3,085,073	33
	B. Capital Expense		
34	Ownership	568,491	34
	C. Ancillary Expense		
35	Special Cost Centers	740,574	35
36	Provider Participation Fee	54,203	36
	D. Other Expenses (specify):		
37	Assisted / Independent Living direct costs	138,131	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,676,561	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,980,988	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,980,988	43

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

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

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

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

Facility Name & ID Number St. Benedict Nursing & Rehab Center # 0044784 Report Period Beginning: 7/01/2010 Ending: 6/30/2011

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	1,544	1,940	$ 91,608	$ 47.22	1
2	Assistant Director of Nursing					2
3	Registered Nurses	23,685	26,363	980,129	37.18	3
4	Licensed Practical Nurses	7,183	8,184	224,679	27.45	4
5	CNAs & Orderlies	71,052	77,913	1,070,244	13.74	5
6	CNA Trainees					6
7	Licensed Therapist	7,147	7,717	336,830	43.65	7
8	Rehab/Therapy Aides	7,022	7,672	192,301	25.07	8
9	Activity Director	1,825	2,033	55,484	27.29	9
10	Activity Assistants	5,986	6,558	75,361	11.49	10
11	Social Service Workers	1,960	2,080	59,157	28.44	11
12	Dietician	1,078	1,142	41,529	36.37	12
13	Food Service Supervisor	1,216	1,551	46,012	29.67	13
14	Head Cook	8,845	9,795	138,422	14.13	14
15	Cook Helpers/Assistants	17,140	19,222	203,113	10.57	15
16	Dishwashers					16
17	Maintenance Workers	4,726	5,421	123,416	22.77	17
18	Housekeepers	15,619	17,159	212,634	12.39	18
19	Laundry	10,007	11,537	126,963	11.00	19
20	Administrator	1,880	2,000	86,931	43.47	20
21	Assistant Administrator	80	80	2,706	33.83	21
22	Other Administrative	16,228	18,035	283,736	15.73	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 Ca MDS COORD	3,237	3,457	143,861	41.61	32
33	Other(specify) Religious Staff	2,583	2,807	65,900	23.48	33
34	TOTAL (lines 1 - 33)	210,043	232,666	$ 4,561,016 *	$ 19.60	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		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)		$		49

C. CONTRACT NURSES

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

Facility Name & ID Number St. Benedict Nursing & Rehab Center # 0044784 Report Period Beginning: 7/01/2010 Ending: 6/30/2011

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Mary Hobbs	Administrator	0	$ 86,931
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 86,931

B. Administrative - Other

Description	Amount
Management Exp / Fee (Exp charged by Resurrection HO)	$ 960,744
TOTAL (agree to Schedule V, line 17, col. 3)	$ 960,744
(Attach a copy of any management service agreement)	

C. Professional Services

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

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 89,285
Unemployment Compensation Insurance	16,984
FICA Taxes	323,570
Employee Health Insurance	621,392
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Life Insurance	9,656
Employee Disability Insurance	29,616
Employee Dental Insurance	20,582
Employee Retirement	399,305
Tuition Reimb and other Assistance benefits	18,520
Disallowed Assisted Living Empl Benefits	(125,101)
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,403,809

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

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
Illinois Council on Long Term Care	4,592
Allscripts	1,775
Miscellaneous Dues/Subscriptions	1,785
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 8,152

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 0
In-State Travel	0
Seminar Expense	0
Entertainment Expense	(0)
TOTAL (agree to Sch. V, line 24, col. 8)	$

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number St. Benedict Nursing & Rehab Center # 0044784 Report Period Beginning: 7/01/2010 Ending: 6/30/2011

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number St. Benedict Nursing & Rehab Center # 0044784 Report Period Beginning: 7/01/2010 Ending: 6/30/2011

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 Council on LTC $4592**

(3) Did the nursing home make political contributions or payments to a politica 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 t end of the fiscal year **No** If YES, what is the capacity **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases **Yes**
What was the average life used for new equipment added during this period **12.5**

(6) Indicate the total amount of both disposable and non-disposable diaper expens and the location of this expense on Sch. V. $ **13,894** Line **10(2)**

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

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

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

(10) Was this home previously operated by a related party (as is defined in the instructions f 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 ove **N/A**

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmer during this cost report period. $ **54,203**
This amount is to be recorded on line 42 of Schedule V

(12) Are there any salary costs which have been allocated to more than one line on Schedule 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 t the Department, in addition to the daily rate, been properly classifie 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 f the patient census listed on page 2, Section B? **Yes-Assisted Living** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attac a schedule which explains how all related costs were allocated to these function

(15) Indicate the cost of employee meals that has been reclassified to employee benefi on Schedule V. $ **0** Has any meal income been offset agains related costs? **Yes** Indicate the amount $ **1,870**

(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 f residents? **No** If YES, please indicate the amount of income earned from such 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 othe times when not in use **N/A**
f. Has the cost for commuting or other personal use of autos been adjuste 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 sucl transportation during this reporting period. $ **0**

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

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

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