		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: 0044792

Facility Name: Villa Scalabrini Nursing And Rehab Center

Address: 480 N. Wolf Road (Number) Northlake (City) 60164 (Zip Code)

County: Cook

Telephone Number: (708) 562-0040 **Fax #** (708) 562-3955

HFS ID Number:

Date of Initial License for Current Owners: 3/1/2000

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 501C(3)

In the event there are further questions about this report, please contact:
Name: Raj Shah **Telephone Number:** (630) 530-7100 Ext 107
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 07/01/2010 to 06/30/2011 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) (Date) 10/28/2011
(Type or Print Name) Nicola Byrne
(Title) Vice President, Finance

Paid Preparer

(Signed) (Date)
(Print Name and Title) Raj Shah, Senior Reimbursement Consultant
(Firm Name & Address) Strategic Reimbursement, Inc., 360 W. Butterfield Road, Suite 310, Elmhurst, IL 60126
(Telephone) (630) 530-7100 Ext 107 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 Villa Scalabrini Nursing And Rehab Center # 0044792 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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	171	Skilled (SNF)	171	62,415	1
2		Skilled Pediatric (SNF/PED)			2
3	82	Intermediate (ICF)	82	29,930	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	253	TOTALS	253	92,345	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	31,384	1,698	18,738	51,820	8
9	SNF/PED					9
10	ICF	14,054	14,693	515	29,262	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	45,438	16,391	19,253	81,082	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.80%

D. How many bed-hold days during this year were paid by the Department?
None (Do not include bed-hold days in Section B.)

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 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 171 and days of care provided 51,820

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: 06/30/2011 Fiscal Year: 06/30/2011

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

Facility Name & ID Number Villa Scalabrini Nursing And Rehab Center # 0044792 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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	626,418		105,261	731,679		731,679		731,679			1
2	Food Purchase		529,249		529,249		529,249	(10,741)	518,508			2
3	Housekeeping	275,024	81,198		356,222		356,222		356,222			3
4	Laundry	182,723	63,476	6,400	252,599		252,599	(7,294)	245,305			4
5	Heat and Other Utilities			329,895	329,895		329,895		329,895			5
6	Maintenance	171,462	30,628	514,438	716,528		716,528		716,528			6
7	Other (specify):*											7
8	**TOTAL General Services**	1,255,627	704,551	955,994	2,916,172		2,916,172	(18,035)	2,898,137			8
	B. Health Care and Programs											
9	Medical Director			13,200	13,200		13,200		13,200			9
10	Nursing and Medical Records	5,370,259	335,993	131,005	5,837,257		5,837,257		5,837,257			10
10a	Therapy	700,323	20,154	77,483	797,960		797,960		797,960			10a
11	Activities	164,274	27,541	3,780	195,595		195,595		195,595			11
12	Social Services	294,683	17,851	733	313,267		313,267		313,267			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	6,529,539	401,539	226,201	7,157,279		7,157,279		7,157,279			16
	C. General Administration											
17	Administrative			1,727,150	1,727,150		1,727,150	(1,454)	1,725,696			17
18	Directors Fees											18
19	Professional Services											19
20	Dues, Fees, Subscriptions & Promotions			8,293	8,293		8,293		8,293			20
21	Clerical & General Office Expenses	703,931	24,740	82,503	811,174		811,174	(6,180)	804,994			21
22	Employee Benefits & Payroll Taxes			2,800,105	2,800,105		2,800,105		2,800,105			22
23	Inservice Training & Education											23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			1,916	1,916		1,916		1,916			25
26	Insurance-Prop.Liab.Malpractice			120,562	120,562		120,562		120,562			26
27	Other (specify):*											27
28	**TOTAL General Administration**	703,931	24,740	4,740,529	5,469,200		5,469,200	(7,634)	5,461,566			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	8,489,097	1,130,830	5,922,724	15,542,651		15,542,651	(25,669)	15,516,982			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 Villa Scalabrini Nursing And Rehab Center #0044792 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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			855,636	855,636		855,636		855,636			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			199,516	199,516		199,516	(3,946)	195,570			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,055,152	1,055,152		1,055,152	(3,946)	1,051,206			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,715,324		1,715,324		1,715,324		1,715,324			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			138,518	138,518		138,518		138,518			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		1,715,324	138,518	1,853,842		1,853,842		1,853,842			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	8,489,097	2,846,154	7,116,394	18,451,645		18,451,645	(29,615)	18,422,030			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 Villa Scalabrini Nursing And Rehab Center # 0044792 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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	(1,272)	2		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	(7,294)	4		8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(3,946)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				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	(17,103)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (29,615)		$	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))**	$ (29,615)		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

Villa Scalabrini Nursing And Rehab Center

ID# 0044792

Report Period Beginning: 07/01/2010

Ending: 06/30/2011

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2	Other Non Op Revenue	(1,454)	17	2
3	Employee Meals	(9,469)	2	3
4	Marketing Exp	(6,180)	21	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**	(17,103)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Villa Scalabrini Nursing And Rehab Center **#** 0044792 **Report Period Beginning:** 07/01/2010 **Ending:** 06/30/2011

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	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(10,741)	0	0	0	0	0	0	0	0	0	0	(10,741)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(7,294)	0	0	0	0	0	0	0	0	0	0	(7,294)	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**	(18,035)	0	0	0	0	0	0	0	0	0	0	(18,035)	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	(1,454)	0	0	0	0	0	0	0	0	0	0	(1,454)	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	(6,180)	0	0	0	0	0	0	0	0	0	0	(6,180)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(7,634)	0	0	0	0	0	0	0	0	0	0	(7,634)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(25,669)	0	0	0	0	0	0	0	0	0	0	(25,669)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Villa Scalabrini Nursing And Rehab Center **#** 0044792 **Report Period Beginning:** 07/01/2010 **Ending:** 06/30/2011

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,946)	0	0	0	0	0	0	0	0	0	0	(3,946)	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**	(3,946)	0	0	0	0	0	0	0	0	0	0	(3,946)	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)**	(29,615)	0	0	0	0	0	0	0	0	0	0	(29,615)	45

Facility Name & ID Number Villa Scalabrini Nursing And Rehab Center # 0044792 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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 Page 6A		See Attached Page 6A		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	Administrative	$ 1,727,150	Resurrection Health Care	100.00%	$ 1,727,150	$	1
2	V								2
3	V	30	Depreciation	276,496	Resurrection Health Care	100.00%	276,496		3
4	V	32	Interest	199,516	Resurrection Health Care	100.00%	199,516		4
5	V	39	Intercompany Pharmacy	1,715,324	Resurrection Health Care	100.00%	1,715,324		5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 3,918,486			$ 3,918,486	$ *	14

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

Resurrection Villa Scalabrini Nursing and 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 Villa Scalabrini Nursing And Rehab Center # 0044792 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	See Attached Pages 7A & 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@bellectric.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 DeFurio	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 Center 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.net
Sister Donna Marie Wolowicki, C.R.	Executive Vice President/CEO 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 Villa Scalabrini Nursing And Rehab Center # 0044792 Report Period Beginning: 07/01/2010 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 office or parent organization costs? (See instructions.) YES [X] NO [ ]

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

Name of Related Organization: Resurrection Health Care
Street Address: 100 North River Road
City / State / Zip Code: Des Plaines, IL 60016
Phone Number: (847) 813-3722
Fax Number: (847) 813-3785

	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	17	Administrative				$	$		$ 1,727,150	1
2										2
3	30	Depreciation							276,496	3
4	32	Interest							199,516	4
5	39	tercompany Pharmacy							1,715,324	5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 3,918,486	25

Facility Name & ID Number Villa Scalabrini Nursing And Rehab Center # 0044792 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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							$	$			$	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								Interest Income			3,946	10
11								Offset Interest Income			(3,946)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

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

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

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

Facility Name & ID Number Villa Scalabrini Nursing And Rehab Center **#** 0044792 **Report Period Beginning:** 07/01/2010 **Ending:** 06/30/2011

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 6.		$	7

Real Estate Tax History:

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

	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 Villa Scalabrini Nursing And Rehab Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0044792

CONTACT PERSON REGARDING THIS REPORT Thomas W. Groenwald

TELEPHONE 847) 813-3722 FAX #: 847) 813-3785

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 not profit entity and does	not pay real estate taxes	$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES N/A NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 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 Villa Scalabrini Nursing And Rehab Center # 0044792 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 195,174 B. General Construction Type: Exterior Brick Frame Steel / Concrete Number of Stories 1

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).

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

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care	696,960	2000	$ 1,500,000	1
2					2
3	TOTALS	696,960		$ 1,500,000	3

Facility Name & ID Number Villa Scalabrini Nursing And Rehab Center # 0044792 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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	253			2000	$ 7,520,069	$ 250,717	7-30	$ 250,717	$	$ 2,849,525	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2001	22,045	1,343	7-20	1,343		21,804	9
10	Various			2002	19,214	895	7-20	895		18,499	10
11	Various			2003	60,584	4,381	5-15	4,381		45,378	11
12	Various			2004	104,281	7,801	5-25	7,801		67,359	12
13	Various			2005	125,857	10,597	5-15	10,597		76,133	13
14	Various			2006	2,235,840	129,170	5-25	129,170		688,529	14
15	Various			2007	193,245	22,558	5-25	22,558		97,964	15
16											16
17	WASCOMAT SUPER HEAVY DUTY HIGH SPEED EXTRACTION WA			2008	17,000	1,133	15	1,133		3,967	17
18	REMOVAL OF OLD TIEL & INSTALL NEW VINYL & BASE			2008	1,425	143	10	143		356	18
19	REMOVE/REPLACE DOORS TO COMPLY W/LIFE SAFETY CODE			2008	25,371	1,691	15	1,691		4,229	19
20	REMOVE & REPLACE VAROIUS DOORS TO COMPLY W/ LIFE SAF			2008	31,009	1,550	20	1,550		5,427	20
21	LIFE SAFETY CODE CONSULTING STUDY PHASE COMPENSATIO			2008	8,293	1,659	5	1,659		5,805	21
22	PROVIDE DOOR HARDWARE FOR DINING ROOM			2008	3,283	657	5	657		2,298	22
23	SERVICE CALL HEAT EXCHANGER NOT PROVIDING ENOUGH HE			2008	6,727	1,345	5	1,345		4,709	23
24	INSTALLATION&REPLACMENT OF DUPLEX SEWAGE EJECTOR S			2008	23,719	2,372	10	2,372		8,302	24
25	CLEAVER BROOKS BOILER FURNISH& INSTALL BURNER HOUSI			2008	5,175	259	20	259		906	25
26	L&M TO REPLACE 1 BELL & GOSSETT HEAT EXCHANGER			2008	10,816	2,163	5	2,163		7,571	26
27	SEAM PRESSURE TRANSDUCERS FOR 3 BOILER HEADS, REPLA			2008	5,340	1,068	5	1,068		2,670	27
28	SEALCOAT, CRACK FILL, AND PAINT PAVEMENT MARKING FOR			2008	3,104	621	5	621		1,552	28
29	PUSH BUTTON COMBO LOCKS			2008	5,034	503	10	503		1,258	29
30	KITCHEN CABINET REMODELING			2008	6,395	426	15	426		1,066	30
31	REMOVE CARPET & INSTALL NEW TILE IN RESIDENT ROOMS, U			2008	4,800	480	10	480		1,200	31
32	NUMEROUS DIRECTIONAL SIGNS THROUGHOUT THE FACILITY			2008	3,398	340	10	340		1,189	32
33	ADDITIOANL MSO FACILITY LICENSE FEE			2008	6,265	1,044	3	1,044		6,265	33
34	INSTALLATION OF ONE STANDARD DROP (WIRING)			2008	1,947	97	20	97		341	34
35	INSTALLATION OF 5 DROPS, CARE PLAN OFFICE, REHAB, SOCIA			2008	5,463	273	20	273		956	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 Villa Scalabrini Nursing And Rehab Center # 0044792 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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	ComEd Smart Ideas Program - Lighting Retrofit	2009	16,167	1,617		1,617		2,425	38
39	Vinyl Tile - 1st floor	2009	4,709	471		471		706	39
40	Carpet - 1st floor Corridor North	2009	11,584	2,317		2,317		3,475	40
41	Remove wallpaper + paint in hallways/rooms	2009	11,150	2,230		2,230		3,345	41
42	ComEd Smart Ideas Program - Lighting Retrofit	2009	4,150	415		415		623	42
43	ComEd Smart Ideas Program - Lighting Retrofit	2009	553	55		55		83	43
44	ComEd Smart Ideas Program - Lighting Retrofit	2009	20,105	2,010		2,010		3,016	44
45	RELOCATE 140-TON MCQUAY CONDENSING UNIT	2009	24,985	2,499		2,499		6,246	45
46	FIRE PROTECTION FOR 6 COOLERS	2009	7,533	753		753		1,883	46
47	Drawings & specs for a new generator	2009	80,604	16,121		16,121		40,302	47
48	Survey of 11 facilities for electrical equipment	2009	4,000	1,333		1,333		3,333	48
49	REPLACE 1 HEAT EXCHANGER BUNDLE ON DOMESTIC HOT WA	2009	8,840	1,768		1,768		4,420	49
50	REMOVAL OF OLD TILE & INSTALL NEW VINYL & BASE	2009	2,750	275		275		688	50
51	SURVEY OF FACILITY FOR ELECTRICAL EQUIPMENT	2009	4,031	1,344		1,344		3,359	51
52	Breezeway Glass Replacement	2009	7,789	519		519		779	52
53	REMODEL CHARLES WALTON ROOM	2009	6,449	430		430		1,075	53
54	CHAPEL SOUND SYSTEM	2009	7,118	712		712		1,780	54
55	PRINTS WITH DOUBLE MAT & FRAME PRESENTATION	2009	1,480	148		148		370	55
56	OAK & PECAN FLOORING W/INSTALLATION	2009	2,413	241		241		603	56
57	REMODEL CHARLES WALTON ROOM	2009	6,000	400		400		1,000	57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 10,688,110	$ 480,946		$ 480,946	$	$ 4,004,769	70

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

Facility Name & ID Number Villa Scalabrini Nursing And Rehab Center # 0044792 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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	
1	Totals from Page 12A, Carried Forward		$ 10,688,110	$ 480,946		$ 480,946	$	$ 4,004,769	1
2	STONHARD FLOORING. REPAIR UNIT C AND G NORTH / STOP LE	2010	14,900	772	10	772		772	2
3	COMED SMART IDEAS - MATERIAL FOR LIGHTING MODIFICATIC	2010	3,327	246	10	246		246	3
4	COMED SMART IDEAS - MATERIAL FOR LIGHTING MODIFICATIC	2010	553	28	10	28		28	4
5	COMED SMART IDEAS - MATERIAL FOR LIGHTING MODIFICATIC	2010	10,468	550	10	550		550	5
6	REPLACE HEAT EXCHANGER IN BOILER ROOM, INSTALL 6" BYP	2010	15,235	948	15	948		1,456	6
7	ELEVATOR # 2 PISTON /CYLINDER REPLACEMENT	2010	15,977	738	20	738		1,138	7
8	Furnish + Install Tone/Visual Nurse Call System	2010	1,314	188	7	188		282	8
9	Booster Heater Replacement	2010	4,041	404	10	404		606	9
10	Installation of new electrical feeds & boosters	2010	5,600	560	10	560		840	10
11	Furnish & Install Tone/Visual Nurse Call System	2010	24,961	3,566	7	3,566		5,349	11
12	INSTALL WIRING, AMPLIFIER SPEAKERS FOR MUSIC IN ALL RES	2010	16,861	3,147	5	3,147		4,833	12
13	Install Flooring System in Resident Bathrooms Unit F	2010	4,500	450	10	450		675	13
14									14
15									15
16	ADDITIONAL WORK NEEDED - REPLACE HEAT EXCHANGER IN E	2011	8,136	203	20	203		203	16
17	REPLACE HEAT EXCHANGER IN BOILER ROOM - INSTALL 6 inch	2011	7,115	178	20	178		178	17
18	NEW SIDE ENTRY TUB FOR UNIT	2011	15,577	897	10	897		897	18
19	INSTALL FIRE PUMPS ALARM SIGNAL	2011	7,265	363	10	363		363	19
20	INSTALL MAGNETIC DOOR HOLDERS ON MULTIPLE DOORS	2011	15,250	763	10	763		763	20
21	REPAIR DOORS INSTALL NEW HARDWARE & NEW CLOSER FOR	2011	5,380	269	10	269		269	21
22	REPAIR OF WANDERGUARD SYSTEM IN 3 UNITS	2011	6,550	328	10	328		328	22
23	REPAIR OF WANDERGUARD SYSTEM IN 3 UNITS	2011	2,400	120	10	120		120	23
24	EMEGENCY REPAIRS IN KITCHEN PLUMBING AREA	2011	3,085	77	20	77		77	24
25	ADD SPRINKLERS TO COMMON AREA RESTROOMS @ BUILDING	2011	2,500	50	25	50		50	25
26									26
27	Home Office Allocation	2011		276,496		276,496			27
28									28
29	Reconciliation to Trial Balance Dep Exp	2011		5,332		5,332			29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 10,879,105	$ 777,618		$ 777,618	$	$ 4,024,790	34

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

Facility Name & ID Number Villa Scalabrini Nursing And Rehab Center # 0044792 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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	$ 2,799,004	$ 73,247	$ 73,247	$	5-20	$ 2,289,854	71
72	Current Year Purchases	54,915	2,735	2,735		5-15	2,735	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 2,853,919	$ 75,982	$ 75,982	$		$ 2,292,589	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	Residence	Cargo Van	2004	$ 20,358	$ 2,036	$ 2,036	$	10	$ 13,233	76
77										77
78										78
79										79
80	TOTALS			$ 20,358	$ 2,036	$ 2,036	$		$ 13,233	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)	$ 15,253,382	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 855,636	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 855,636	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 6,330,612	85	

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Villa Scalabrini Nursing And Rehab Center # 0044792 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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:				$			3
4	Additions				N/A			4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. N/A
This amount was calculated by dividing the total amount to be amortized N/A
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: $ 51,959 Description: See Attached Page 14A for the details.
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

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

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

Provider Number: 0044792

FYE: 6/30/2011

Attachment to Schedule XII, Line 16- Equipment Rental Cost

Sub Acct 7020

Equipment	Amount
Copiers	14,189
Medical Equipment	37,770
Total Equipment Lease Exp	51,959

Facility Name & ID Number Villa Scalabrini Nursing And Rehab Center # 0044792 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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.

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 Villa Scalabrini Nursing And Rehab Center # 0044792 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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	10(A)	3533	hrs	$ 152,650	379	$ 24,627	$	3,912	$ 177,277	1
2	Licensed Speech and Language Development Therapist		795	hrs	41,002				795	41,002	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10(A)	6299	hrs	275,268	7	439		6,306	275,707	4
5	Physician Care			visits							5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy	39		# of prescrpts				1,715,324		1,715,324	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				$ 468,920	386	$ 25,066	$ 1,715,324	11,013	$ 2,209,310	14

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

Facility Name & ID Number Villa Scalabrini Nursing And Rehab Center # 0044792 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/2011 (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	$ 912,265	$ 912,265	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 347,725)	114,630	114,630	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	4,442	4,442	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Premier Receivable	31,300	31,300	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,062,637	$ 1,062,637	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	1,500,000	1,500,000	13
14	Buildings, at Historical Cost	12,337,731	12,337,731	14
15	Leasehold Improvements, at Historical Cost	23,837	23,837	15
16	Equipment, at Historical Cost	1,314,095	1,314,095	16
17	Accumulated Depreciation (book methods)	(6,330,612)	(6,330,612)	17
18	Deferred Charges	78,000	78,000	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)**	$ 8,923,051	$ 8,923,051	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 9,985,688	$ 9,985,688	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 76,969	$ 76,969	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	56,027	56,027	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 From Affiliates	(4,612,930)	(4,612,930)	36
37	Medicare Settlement	114,978	114,978	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ (4,364,956)	$ (4,364,956)	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)**	$ (4,364,956)	$ (4,364,956)	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 14,350,644	$ 14,350,644	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 9,985,688	$ 9,985,688	48

***(See instructions.)**

Facility Name & ID Number Villa Scalabrini Nursing And Rehab Center # 0044792 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 13,025,174	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 13,025,174	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,324,755	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) **cont. allowance to agree with income stmt**	715	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 1,325,470	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)**	$ 14,350,644	24 *

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

Facility Name & ID Number Villa Scalabrini Nursing And Rehab Center # 0044792 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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	$ 26,328,347	1
2	Discounts and Allowances for all Levels	(6,785,414)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 19,542,933	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	10,741	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	7,294	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 18,035	23
	D. Non-Operating Revenue		
24	Contributions	159,786	24
25	Interest and Other Investment Income***	3,946	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 163,732	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Please Refer to Page 19A for the details	51,700	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 51,700	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 19,776,400	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,916,172	31
32	Health Care	7,157,279	32
33	General Administration	5,469,200	33
	B. Capital Expense		
34	Ownership	1,055,152	34
	C. Ancillary Expense		
35	Special Cost Centers	1,715,324	35
36	Provider Participation Fee	138,518	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 18,451,645	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,324,755	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,324,755	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.**

Villa Scalbrini Nursing and Rehab Center
Medicaid Provider Number: 0044792
FYE 6/30/2011
Attchment to Line 28, Schedule XVII - Other Revenue

Description	Amount	Remark
Net Assets Released from restrictions	15,283	Not an income
Net Assets Released from restrictions	6,101	Not an income
Net Assets Released from restrictions	1,417	Not an income
Net Assets Released from restrictions	716	Not an income
Gain on disposal of assets	9,434	Not subject to offset
Admin-Rental Revenue	17,295	Inter company transfer. Not subject to o
Admin - Other Revenue	1,454	Offset on Page 5A
Total - Other Revenue	51,700	

Attachment to Line 25 , Schedule XVII - Interest and Other Investment Income

Interest Income	3,946	
Interest Expenses	199,516	Page 6
Interest income offset - lower of two	3,946	

Facility Name & ID Number Villa Scalabrini Nursing And Rehab Center # 0044792 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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	1,884	2,080	$ 100,933	$ 48.53	1
2	Assistant Director of Nursing	1,744	2,056	91,023	44.27	2
3	Registered Nurses	68,365	75,982	2,703,265	35.58	3
4	Licensed Practical Nurses	8,870	10,123	268,558	26.53	4
5	CNAs & Orderlies	137,364	151,654	2,047,375	13.50	5
6	CNA Trainees					6
7	Licensed Therapist	10,380	11,248	493,942	43.91	7
8	Rehab/Therapy Aides	14,296	15,639	307,879	19.69	8
9	Activity Director	1,744	2,005	42,407	21.15	9
10	Activity Assistants	10,605	11,786	130,555	11.08	10
11	Social Service Workers	1,000	1,096	30,279	27.63	11
12	Dietician	4,373	4,557	87,259	19.15	12
13	Food Service Supervisor	2,929	3,208	69,790	21.75	13
14	Head Cook	10,188	11,061	158,930	14.37	14
15	Cook Helpers/Assistants	23,944	26,608	290,420	10.91	15
16	Dishwashers					16
17	Maintenance Workers	7,573	8,431	169,974	20.16	17
18	Housekeepers	17,949	19,916	221,327	11.11	18
19	Laundry	14,020	16,412	207,025	12.61	19
20	Administrator	2,000	2,303	115,676	50.23	20
21	Assistant Administrator	1,856	2,080	51,104	24.57	21
22	Other Administrative	23,032	25,324	419,700	16.57	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 Other HC Staff	6,348	6,877	253,081	36.80	32
33	Other(specify) Religious	10,492	10,654	228,595	21.46	33
34	TOTAL (lines 1 - 33)	380,956	421,100	$ 8,489,097 *	$ 20.16	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	13,200	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)		$ 13,200		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 Villa Scalabrini Nursing And Rehab Center # 0044792 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Mathew, Abe	Administrator	0	$ 42,530
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 42,530

B. Administrative - Other

Description	Amount
Management Fees	$ 1,727,150
TOTAL (agree to Schedule V, line 17, col. 3)	$ 1,727,150
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
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	$ 159,496
Unemployment Compensation Insurance	30,516
FICA Taxes	603,079
Employee Health Insurance	1,173,399
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Life Insurance	17,258
Employee Group Disablility	52,666
Employee Retirement Plan	730,604
Employee Assistance and Other Benefits	33,087
TOTAL (agree to Schedule V, line 22, col.8)	$ 2,800,105

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	1,010
Health Care Worker Background Check	
(Indicate # of checks performed)	
Illinois	3,859
All Script	2,338
Dutton An	500
Other	586
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 8,293

G. Schedule of Travel and Seminar**

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

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Villa Scalabrini Nursing And Rehab Center # 0044792 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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			$		$	$	$	$	$	$	$	$	$
2	N/A	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 Villa Scalabrini Nursing And Rehab Center # 0044792 Report Period Beginning: 07/01/2010 Ending: 06/30/2011

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? **No**
If YES, give association name and amount.

(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 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? **11.5 Yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **25,060** Line **10(2)**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen during this cost report period. $ **138,518**
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 tc the Department, in addition to the daily rate, been properly classifiec 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 fo 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. $ **9,469** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **10,741**

(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 fo 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? **N/A**
d. Have vehicle usage logs been maintained? **Adequate Records Have Been 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 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 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