FOR BHF USE

LL1

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.

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

I. IDPH License ID Number: 0044024

Facility Name: Saint Clare Home

Address: 5533 North Galena Road (Number) Peoria Heights (City) 61616 (Zip Code)

County: Peoria

Telephone Number: (309) 682-5428 **Fax #** ( )

HFS ID Number:

Date of Initial License for Current Owners: 09/01/1998

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Mary Monroe **Telephone Number:** (309) 671-5334
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 10/01/2011 to 09/30/2012 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)
(Type or Print Name) Donald Dadds
(Title) Administrator

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) Ken Harbaugh, Vice President & CFO
(Firm Name & Address) Saint Francis Medical Center, 530 NE Glen Oak Ave; Peoria, IL 61637-0001
(Telephone) (309) 671-4398 Fax # ( )

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 Saint Clare Home # 0044024 Report Period Beginning: 10/01/2011 Ending: 09/30/2012

III. STATISTICAL DATA

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

	1 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	60	Skilled (SNF)	60	21,960	1
2		Skilled Pediatric (SNF/PED)			2
3	34	Intermediate (ICF)	34	12,444	3
4		Intermediate/DD			4
5	4	Sheltered Care (SC)	4	1,464	5
6		ICF/DD 16 or Less			6
7	98	TOTALS	98	35,868	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	11,119	11,728	3,630	26,477	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC	232	802		1,034	12
13	DD 16 OR LESS					13
14	TOTALS	11,351	12,530	3,630	27,511	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.70%

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

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)

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 [XX]

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

I. On what date did you start providing long term care at this location?
Date started 09/01/1998

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [XX]

K. Was the facility certified for Medicare during the reporting year?
YES [XX] NO [ ] If YES, enter number of beds certified 60 and days of care provided 3,630

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRUAL [XX] MODIFIED CASH* [ ] CASH* [ ]

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

Tax Year: _____ Fiscal Year: _____

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

Facility Name & ID Number Saint Clare Home # 0044024 Report Period Beginning: 10/01/2011 Ending: 09/30/2012

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	265,263	1,071	29,707	296,041		296,041		296,041			1
2	Food Purchase		261,265		261,265		261,265		261,265			2
3	Housekeeping	133,537	15,135		148,672		148,672		148,672			3
4	Laundry	43,751	10,563	10,130	64,444		64,444		64,444			4
5	Heat and Other Utilities			89,140	89,140		89,140		89,140			5
6	Maintenance	57,468	57,686	53,370	168,524		168,524		168,524			6
7	Other (specify):*											7
8	TOTAL General Services	500,019	345,720	182,347	1,028,086		1,028,086		1,028,086			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,504,558	130,832	689,923	2,325,313		2,325,313		2,325,313			10
10a	Therapy			879,690	879,690	(205,279)	674,411		674,411			10a
11	Activities	85,041	20,105	14,668	119,814	5,068	124,882		124,882			11
12	Social Services	32,244	643	813	33,700		33,700		33,700			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* LAB			21,727	21,727	(21,727)						15
16	TOTAL Health Care and Programs	1,621,843	151,580	1,606,821	3,380,244	(221,938)	3,158,306		3,158,306			16
	C. General Administration											
17	Administrative	70,004		98	70,102		70,102		70,102			17
18	Directors Fees											18
19	Professional Services			30,137	30,137	4,877	35,014	494,127	529,141			19
20	Dues, Fees, Subscriptions & Promotions			233,034	233,034	(201,712)	31,322	(12,247)	19,075			20
21	Clerical & General Office Expenses	220,505		80,591	301,096		301,096		301,096			21
22	Employee Benefits & Payroll Taxes			695,952	695,952		695,952		695,952			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,340	2,340		2,340		2,340			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			42,962	42,962		42,962		42,962			26
27	Other (specify):*	50,294	1,104	455	51,853		51,853		51,853			27
28	TOTAL General Administration	340,803	1,104	1,085,569	1,427,476	(196,835)	1,230,641	481,880	1,712,521			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,462,665	498,404	2,874,737	5,835,806	(418,773)	5,417,033	481,880	5,898,913			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 Saint Clare Home #0044024 **Report Period Beginning:** 10/01/2011 **Ending:** 09/30/2012

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			271,181	271,181	(4,877)	266,304		266,304			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			172,436	172,436		172,436	(486)	171,950			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			443,617	443,617	(4,877)	438,740	(486)	438,254			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					227,006	227,006		227,006			39
40	Barber and Beauty Shops			15,219	15,219		15,219		15,219			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					196,644	196,644		196,644			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			15,219	15,219	423,650	438,869		438,869			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,462,665	498,404	3,333,573	6,294,642		6,294,642	481,394	6,776,036			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 Saint Clare Home # 0044024 Report Period Beginning: 10/01/2011 Ending: 09/30/2012

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				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				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(486)	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	(1,283)	20		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	(5,067)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(5,897)	20		28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (12,733)		$	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)	494,127	19	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 494,127		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 481,394		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			21,727	15	42
43	Prescription Drugs			206,551	10a	43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$ 228,278		47

Saint Clare Home

ID# 0044024

Report Period Beginning: 10/01/2011

Ending: 09/30/2012

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				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**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Saint Clare Home # 0044024 **Report Period Beginning:** 10/01/2011 **Ending:** 09/30/2012

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

	Operating Expenses	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)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	494,127	0	0	0	0	0	0	0	0	0	0	494,127	19
20	Fees, Subscriptions & Promotions	(12,247)	0	0	0	0	0	0	0	0	0	0	(12,247)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	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**	481,880	0	0	0	0	0	0	0	0	0	0	481,880	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	481,880	0	0	0	0	0	0	0	0	0	0	481,880	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Saint Clare Home # 0044024 **Report Period Beginning:** 10/01/2011 **Ending:** 09/30/2012

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	0	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	(486)	0	0	0	0	0	0	0	0	0	0	(486)	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**	(486)	0	0	0	0	0	0	0	0	0	0	(486)	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)**	481,394	0	0	0	0	0	0	0	0	0	0	481,394	45

Facility Name & ID Number Saint Clare Home # 0044024 Report Period Beginning: 10/01/2011 Ending: 09/30/2012

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
OSF Healthcare System	100					

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		Home Office Costs	$ 25,137	OSF Healthcare System	100.00%	$ 524,141	$ 499,004	1
2	V		Home Office Costs	4,877				(4,877)	2
3	V								3
4	V								4
5	V								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			$ 30,014			$ 524,141	$ * 494,127	14

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

Facility Name & ID Number Saint Clare Home # 0044024 Report Period Beginning: 10/01/2011 Ending: 09/30/2012

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	Sister Judith Ann Duvall, O.S.F.	BOD						1
2	Sister Marie Elena Padilla, O.S.F.	BOD						2
3	Sister Diane Marie McGrew, O.S.F.	BOD						3
4	Sister Agnes Joseph Williams, O.S.F.	BOD						4
5	Sister Theresa Ann Brazeau, O.S.F.	BOD						5
6	Sister Rose Therese Mann, O.S.F	BOD						6
7	Kevin D. Schoeplein	BOD						7
8	Vance C. Parkhurst	BOD						8
9	James W. Girardy, M.D.	BOD						9
10	Gerald J. McShane, M.D.	BOD						10
11	Susan K. Campbell, R.N.	BOD						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 Saint Clare Home # 0044024 Report Period Beginning: 10/01/2011 Ending: 09/30/2012

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									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Saint Clare Home # 0044024 Report Period Beginning: 10/01/2011 Ending: 9/30/2012

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	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						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Saint Clare Home # 0044024 Report Period Beginning: 10/01/2011 Ending: 09/30/2012

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	OSF Healthcare System	X		Cash Advance	As Required	10/01/2011	3,398,000	4,316,000		4.5000	172,436	6
7												7
8												8
9	TOTAL Facility Related						$ 3,398,000	$ 4,316,000			$ 172,436	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 3,398,000	$ 4,316,000			$ 172,436	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 Saint Clare Home # 0044024 **Report Period Beginning:** 10/01/2011 **Ending:** 09/30/2012

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 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 2012 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:		
	2007	8
	2008	9
	2009	10
	2010	11
	2011	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	$	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.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Saint Clare Home COUNTY Peoria

FACILITY IDPH LICENSE NUMBER 0044024

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2011 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 2011.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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 Saint Clare Home # 0044024 Report Period Beginning: 10/01/2011 Ending: 09/30/2012

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 26,500 B. General Construction Type: Exterior Brick/Wood Frame Wood Number of Stories 1

C. Does the Operating Entity? [XX] (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? [XX] (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).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [XX] 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				$ 224,000	1
2					2
3	TOTALS			$ 224,000	3

Facility Name & ID Number Saint Clare Home # 0044024 Report Period Beginning: 10/01/2011 Ending: 09/30/2012

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	98			1998	$ 2,682,500	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	NURSE CALL-DOOR ALARM			1999	3,525						9
10	NURSE CALL SYSTEM			1999	13,260						10
11	DOOR ALARM SYSTEM			1999	1,275						11
12	BACK FLOW PREVENTOR			1999	1,932						12
13	SEWAGE EJECTOR PUMP			1999	3,800						13
14	KITCHEN CABINETS			1999	517						14
15	CHAPEL CONSTRUCTION			1999	1,760						15
16	ROOFTOP AIR CONDITIONERS			2000	328,932						16
17	BLINDS,SHADES,ETC-LOBBY			2000	1,296						17
18	CORRIDOR RENOVATIONS			2000	6,815						18
19	INTERIOR SIGNS-LIBRARY			2000	720						19
20	CUBICLE CURTAINS-RES RMS			2000	4,020						20
21	WALLCOVER,PAINT-RES RMS			2000	9,570						21
22	CARPET-RESIDENT ROOMS			2000	16,100						22
23	BLINDS,SHADES,ETC-RES RMS			2000	5,264						23
24	CORRIDOR RENOVATIONS			2000	8,251						24
25	WALLCOVER,PAINT-HALLWAYS			2000	24,492						25
26	CARPET-HALLWAYS			2000	28,948						26
27	PAINTING,WALLCOVERING			2000	7,300						27
28	CORRIDOR RENOVATIONS			2000	8,762						28
29	HEAT/COOL PUMP			2000	8,790						29
30	SMOKE DETECTORS-18,WIRING			2000	3,300						30
31	CHAPEL RENOVATION			2000	32,210						31
32	AUTO DOOR OPENER (1995)			2001	1,919						32
33	DOOR ALARM MONITOR SYS (1993)			2001	12,678						33
34	ROOFTOP AIR CONDITIONERS			2001	88,341						34
35											35
36	Book Depreciation					217,539		217,539		3,174,944	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 Saint Clare Home # 0044024 Report Period Beginning: 10/01/2011 Ending: 09/30/2012

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	CARPET-HALLWAYS	2001	$ 888	$		$	$	$	37
38	INTERIOR DESIGN-CURTAINS	2001	104						38
39	INTERIOR DESIGN-CABINETS	2001	69						39
40	CARPET, VINYL FLOORING	2001	39,369						40
41	PAINTING,WALLCOVERING	2001	39,543						41
42	DOOR UPGRADES, RAILS, LIGHTS	2001	9,880						42
43	WINDOW SHADES, BLINDS	2002	9,136						43
44	SECURITY SYSTEM DOOR LOCKS	2002	38,542						44
45	PAINT,WALLCOVER-NORTH WING	2002	17,518						45
46	RAILS,OVERBED LIGHTS-NO WING	2002	5,643						46
47	TELEPHONE SYSTEM-1	2003	13,908						47
48	OVER-THE-BED LIGHTS-25	2003	3,210						48
49	CORNICES-20, SHADES-20	2004	7,600						49
50	PAINTING	2004	21,350						50
51	VINYL FLOORING	2004	7,297						51
52	WATER HEATER REPLACE	2004	60,098						52
53	FIRE ALARM SYSTEM-1	2004	44,859						53
54	VINYL FLOORING	2004	13,585						54
55	PATIENT ROOM LATCHES	2004	15,545						55
56	BOILER REPLACEMENT-1	2005	89,488						56
57	HVAC SYSTEM-1	2005	79,875						57
58	HVAC SYSTEM-1	2006	186,467						58
59									59
60	1-Sidewalk	2007	39,339	2,623		2,623	0	15,261	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)		$ 4,049,590	$ 220,162		$ 220,162	$ 0	$ 3,190,204	70

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

Facility Name & ID Number Saint Clare Home # 0044024 Report Period Beginning: 10/01/2011 Ending: 09/30/2012

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		$ 4,049,590	$ 220,162		$ 220,162	$ 0	$ 3,190,204	1
2	1 STORAGE SHED	2008	22,665						2
3	Air Conditioners - Resident Rooms	2008	135,096						3
4	1-HVAC Revisions / Roof Replace	2008	59,035						4
5	1-Fire Protection Sprinkler System	2008	169,720						5
6	1-Fire Protection Sprinkler System	2008	22,719						6
7	1-Fire Protection Sprinkler System	2008	2,476						7
8	1-Fire Protection Sprinkler System	2008	375						8
9	1-Fire Protection Sprinkler System	2008	20,609						9
10									10
11									11
12									12
13									13
14	1 storage shed	2009	17,555						14
15	1-Fire Protection Sprinkler System	2009	67,352						15
16	Handicap Ramp	2010	1,919						16
17	Handicap Ramp	2010	14,930						17
18	Therapy Gym Renovation	2011	17,377						18
19	Therapy Gym Renovation	2011	17,377						19
20	Therapy Gym Renovation	2011	17,377						20
21									21
22	Roadway Overlay	2011	71,778	8,972		8,972		17,945	22
23	Handicap Ramp	2012	27,490						23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,735,440	$ 229,134		$ 229,134	$ 0	$ 3,208,149	34

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

Facility Name & ID Number Saint Clare Home # 0044024 Report Period Beginning: 10/01/2011 Ending: 09/30/2012

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	$ 809,622	$ 36,856	$ 36,856	$		$ 654,035	71
72	Current Year Purchases	7,719	314	314			314	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 817,341	$ 37,170	$ 37,170	$		$ 654,349	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)	$ 5,776,781	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 266,304	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 266,304	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 0	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,862,498	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 Saint Clare Home # 0044024 Report Period Beginning: 10/01/2011 Ending: 09/30/2012

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								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.	/2013	$
13.	/2014	$
14.	/2015	$

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: $ _____ Description: _____
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number Saint Clare Home # 0044024 Report Period Beginning: 10/01/2011 Ending: 09/30/2012

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
   - [XX] 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 Saint Clare Home # 0044024 Report Period Beginning: 10/01/2011 Ending: 09/30/2012

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$ 248,775	$		$ 248,775	1
2	Licensed Speech and Language Development Therapist		hrs			81,634			81,634	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			342,730			342,730	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				206,551		206,551	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			$		$ 673,139	$ 206,551		$ 879,690	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 Saint Clare Home # 0044024 **Report Period Beginning:** 10/01/2011 **Ending:** 09/30/2012

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 09/30/2012 (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	$ 100,431	$	1
2	Cash-Patient Deposits	6,069		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 260,076)	1,408,060		3
4	Supply Inventory (priced at)	37,211		4
5	Short-Term Investments			5
6	Prepaid Insurance	301,789		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Exchange Account	14,115		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,867,674	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	224,000		13
14	Buildings, at Historical Cost	4,735,440		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	817,341		16
17	Accumulated Depreciation (book methods)	(3,862,498)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,914,284	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,781,958	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 126,139	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	7,441		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	90,010		30
31	Accrued Taxes Payable (excluding real estate taxes)	11,272		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	12,240		35
	Other Current Liabilities(specify):			
36	Accrued Vacation/Othr P/R Deduct	248,278		36
37	Reimb. Due Medicare	68,019		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 563,398	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	654,000		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Adv. Due Corp. Term	3,662,000		43
44	Asset Retirement Obligation	61,200		44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 4,377,200	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,940,598	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,158,640)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,781,958	$	48

***(See instructions.)**

Facility Name & ID Number Saint Clare Home **#** 0044024 **Report Period Beginning:** 10/01/2011 **Ending:** 09/30/2012

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ (410,001)	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (410,001)	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(748,639)	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)**	$ (748,639)	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,158,640)	24	*

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

Facility Name & ID Number Saint Clare Home # 0044024 Report Period Beginning: 10/01/2011 Ending: 09/30/2012

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,356,508	1
2	Discounts and Allowances for all Levels	(2,378,951)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,977,557	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,141,501	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,141,501	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		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	331,905	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	22,787	19
20	Radiology and X-Ray	11,069	20
21	Other Medical Services	57,899	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 423,660	23
	D. Non-Operating Revenue		
24	Contributions	2,800	24
25	Interest and Other Investment Income***	486	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 3,286	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,546,004	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,028,086	31
32	Health Care	3,380,244	32
33	General Administration	1,230,832	33
	B. Capital Expense		
34	Ownership	443,617	34
	C. Ancillary Expense		
35	Special Cost Centers	15,219	35
36	Provider Participation Fee	196,644	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,294,642	40
41	**Income before Income Taxes (line 30 minus line 40)****	(748,638)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (748,638)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$	49

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

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

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

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

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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	1,709	2,058	$ 67,648	$ 32.87	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,345	7,000	180,259	25.75	3
4	Licensed Practical Nurses	20,177	24,042	521,087	21.67	4
5	CNAs & Orderlies	48,384	53,570	721,996	13.48	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	6,304	6,606	85,041	12.87	10
11	Social Service Workers	1,989	2,108	32,244	15.30	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	19,887	21,575	265,263	12.29	15
16	Dishwashers					16
17	Maintenance Workers	3,174	3,510	57,468	16.37	17
18	Housekeepers	11,230	12,034	133,537	11.10	18
19	Laundry	3,700	4,298	43,751	10.18	19
20	Administrator	1,040	1,040	70,004	67.31	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,978	11,281	220,505	19.55	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	1,060	1,138	13,568	11.92	31
32	Other Health Care(specify)					32
33	Other(specify) Chaplain	1,966	2,091	50,294	24.05	33
34	TOTAL (lines 1 - 33)	136,943	152,351	$ 2,462,665 *	$ 16.16	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				36
37	Medical Records Consultant		1,900	21	37
38	Nurse Consultant				38
39	Pharmacist Consultant		5,295	10	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		813	12	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 8,008		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	491	$ 17,607	10	50
51	Licensed Practical Nurses	8,165	272,294	10	51
52	Certified Nurse Assistants/Aides	20,215	361,108	10	52
53	TOTAL (lines 50 - 52)	28,872	$ 651,009		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Donald Dadds	Interim Administrator		$ 70,004
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 70,004

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
OSF Healthcare System	Mgmt Fee	$ 25,137
KPMG LLP	Audit	5,000
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 30,137

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$
Unemployment Compensation Insurance	
FICA Taxes	
Employee Health Insurance	
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
TOTAL (agree to Schedule V, line 22, col.8)	$

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	3,618
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
Promtional Advertising	5,067
Dues & Subscriptions	16,723
Facility License Renewal	4,631
Less: Public Relations Expense	( )
Non-allowable advertising	(5,067)
Yellow page advertising	(5,897)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 19,075

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	1,016
Seminar Expense	1,324
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,340

**See instructions.

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

Facility Name & ID Number Saint Clare Home # 0044024 Report Period Beginning: 10/01/2011 Ending: 09/30/2012

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. **IL Health Care Assoc - $ 4958**

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

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

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **8 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **23,962** Line **10**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **196,644**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

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

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **N/A** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100%**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **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. $

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

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

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