		FOR BHF USE					

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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: 0044776

Facility Name: St Andrew Life Center

Address: 7000 North Newark (Number) Niles (City) 60714 (Zip Code)

County: Cook

Telephone Number: (847) 647-8332 **Fax #** (847) 647-7073

HFS ID Number:

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

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code	501(c)(3)		Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

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

II. CERTIFICATION BY AUTHORIZE

I have examined the contents of th
State of Illinois, for the period from
and certify to the best of my knowled
are true, accurate and complete state
applicable instructions. Declaration
is based on all information of which p

Intentional misrepresentation or fa
in this cost report may be punishable

Officer or Administrator of Provider

(Signed)
(Type or Print Name) Mike
(Title) System Director - R

Paid Preparer

(Signed)
(Print Name and Title) Patrick Szajk, Senior Cons
(Firm Name & Address) Strategic Rei, 360 W. Butte
(Telephone) (630) 530-71

MAIL TO: BUREAU OF F
ILLINOIS DEPT OF HEA
201 S. Grand Avenue East
Springfield, IL 62763-0001

:TANT NOTICE
Y IS REQUESTING DISCLOSURE OF INFORMATION
ESSARY TO ACCOMPLISH THE STATUTORY
OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
)RMATION IS MANDATORY. FAILURE TO PROVIDE
IATION ON OR BEFORE THE DUE DATE WILL
ESSATION OF PROGRAM PAYMENTS. THIS FORM
PPROVED BY THE FORMS MANAGEMENT CENTER.

D FACILITY OFFICER

ıe accompanying report to the
7/1/2011 to 6/30/2012
lge and belief that the said contents
:ements in accordance with
of preparer (other than provider)
preparer has any knowledge.

alsification of any information
: by fine and/or imprisonment.

10/30/2012
(Date)

: Volante

eimbursement

10/30/2012
(Date)

:ovics
ultant

mbursement, Inc.
rfield Road, Suite 310, Elmhurst, IL 60126
00 **Fax #: (630) 530-7106**

HEALTH FINANCE
LTHCARE AND FAMILY SERVICES

Phone # (217) 782-1630

Facility Name & ID Number St Andrew Life Center # 0044776 Report Period Beginning: 7/1/2011 Ending: 6/30/2012

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 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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	55	Intermediate (ICF)	55	20,130	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	55	TOTALS	55	20,130	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					8
9	SNF/PED					9
10	ICF	10,271	8,230		18,501	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,271	8,230		18,501	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.91%

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

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

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

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

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

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

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

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

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

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

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

Tax Year: 6/30/2012 Fiscal Year: 6/30/2012

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

Facility Name & ID Number St Andrew Life Center # 0044776 Report Period Beginning: 7/1/2011 Ending: 6/30/2012

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

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY 9	10	
	A. General Services											
1	Dietary	393,526	36,903	8,535	438,964		438,964	(290,015)	148,949			1
2	Food Purchase		424,046		424,046		424,046	(289,529)	134,517			2
3	Housekeeping	202,913	7,892		210,805		210,805	(139,275)	71,530			3
4	Laundry	45,228	29,070	744	75,042		75,042	(66,774)	8,268			4
5	Heat and Other Utilities			183,025	183,025		183,025	(120,921)	62,104			5
6	Maintenance	191,775	15,849	189,625	397,249		397,249	(264,307)	132,942			6
7	Other (specify):*											7
8	**TOTAL General Services**	833,442	513,760	381,929	1,729,131		1,729,131	(1,170,821)	558,310			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,009,574	44,505	1,460	1,055,539		1,055,539	(14,539)	1,041,000			10
10a	Therapy	3,709			3,709		3,709		3,709			10a
11	Activities	118,343	4,750	332	123,425		123,425		123,425			11
12	Social Services	239,086	24,899	3,038	267,023		267,023	(5,256)	261,767			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,370,712	74,154	4,830	1,449,696		1,449,696	(19,795)	1,429,901			16
	C. General Administration											
17	Administrative	92,358		651,081	743,439		743,439		743,439			17
18	Directors Fees											18
19	Professional Services											19
20	Dues, Fees, Subscriptions & Promotions			2,411	2,411		2,411		2,411			20
21	Clerical & General Office Expenses	332,049	12,758	69,343	414,150		414,150	(115,065)	299,085			21
22	Employee Benefits & Payroll Taxes			835,325	835,325		835,325	(257,522)	577,803			22
23	Inservice Training & Education											23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			226	226		226		226			25
26	Insurance-Prop.Liab.Malpractice			236,208	236,208		236,208		236,208			26
27	Other (specify):*											27
28	**TOTAL General Administration**	424,407	12,758	1,794,594	2,231,759		2,231,759	(372,587)	1,859,172			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,628,561	600,672	2,181,353	5,410,586		5,410,586	(1,563,203)	3,847,383			29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification

Facility Name & ID Number St Andrew Life Center #0044776 **Report Period Beginning:** 7/1/2011 **Ending:** 6/30/2012

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			759,486	759,486		759,486	(501,778)	257,708			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			202,082	202,082		202,082		202,082			32
33	Real Estate Taxes			7,132	7,132		7,132	(7,132)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			3,947	3,947		3,947		3,947			35
36	Other (specify):*											36
37	**TOTAL Ownership**			972,647	972,647		972,647	(508,910)	463,737			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		222,263		222,263		222,263	1,852	224,115			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			104,410	104,410		104,410		104,410			42
43	Other (specify):* **Asstd / Ind Living**	582,841	12,771	208,304	803,916		803,916	(803,916)				43
44	**TOTAL Special Cost Centers**	582,841	235,034	312,714	1,130,589		1,130,589	(802,064)	328,525			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,211,402	835,706	3,466,714	7,513,822		7,513,822	(2,874,177)	4,639,645			45

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

Facility Name & ID Number St Andrew Life Center # 0044776 Report Period Beginning: 7/1/2011 Ending: 6/30/2012

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	(9,370)	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	(17,195)	4		8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotiona	(7,285)	21		25
26	Income Taxes and Illinois Persona Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule Page 5A	(2,840,327)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (2,874,177)		$	30

BHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organizatio Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (2,874,177)		37

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

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

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

STATE OF ILLINOIS **Page 5A**

St Andrew Life Center

ID# **0044776**

Report Period Beginning: **7/1/2011**

Ending: **6/30/2012**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Offset Assisted Living Direct Wages	$ (582,841)	43	1
2	Offset Assisted Living Direct Supply costs	(12,771)	43	2
3	Offset Assisted Living Direct Other costs	(208,304)	43	3
4	Offset OH Benefit Exp.Allocated to Assisted Living	(257,522)	22	4
5	Offset Depreciation allocated to Assisted Living	(501,778)	30	5
6	Offset Maintenance allocated to Assisted Living	(262,455)	6	6
7	Offset Utilities cost allocated to Assisted Living	(120,921)	5	7
8	Offset Housekeeping allocated to Assisted Living	(139,275)	3	8
9	Offset Dietary costs allocated to Assisted Living	(290,015)	1	9
10	Offset Food expense allocated to Assisted Living	(280,159)	2	10
11	Offset Laundry costs allocated to Assisted Living	(49,579)	4	11
12				12
13	Miscellaneous Chapel Revenue	(5,256)	12	13
14	Miscellaneous Supply Revenue	(14,539)	10	14
15	Miscellaneous Revenue	(107,780)	21	15
16	Real Estate Tax expense	(7,132)	33	16
17				17
18	Lab Expense - Reclass Outside Services	(1,852)	6	18
19	Lab Expense - Reclass Outside Services	1,852	39	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**	(2,840,327)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number St Andrew Life Center # 0044776 **Report Period Beginning:** 7/1/2011 **Ending:** 6/30/2012

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	(290,015)	0	0	0	0	0	0	0	0	0	0	(290,015)	1
2	Food Purchase	(289,529)	0	0	0	0	0	0	0	0	0	0	(289,529)	2
3	Housekeeping	(139,275)	0	0	0	0	0	0	0	0	0	0	(139,275)	3
4	Laundry	(66,774)	0	0	0	0	0	0	0	0	0	0	(66,774)	4
5	Heat and Other Utilities	(120,921)	0	0	0	0	0	0	0	0	0	0	(120,921)	5
6	Maintenance	(264,307)	0	0	0	0	0	0	0	0	0	0	(264,307)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(1,170,821)	0	0	0	0	0	0	0	0	0	0	(1,170,821)	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	(14,539)	0	0	0	0	0	0	0	0	0	0	(14,539)	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	(5,256)	0	0	0	0	0	0	0	0	0	0	(5,256)	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**	(19,795)	0	0	0	0	0	0	0	0	0	0	(19,795)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(115,065)	0	0	0	0	0	0	0	0	0	0	(115,065)	21
22	Employee Benefits & Payroll Taxes	(257,522)	0	0	0	0	0	0	0	0	0	0	(257,522)	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**	(372,587)	0	0	0	0	0	0	0	0	0	0	(372,587)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(1,563,203)	0	0	0	0	0	0	0	0	0	0	(1,563,203)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number St Andrew Life Center **#** 0044776 **Report Period Beginning:** 7/1/2011 **Ending:** 6/30/2012

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(501,778)	0	0	0	0	0	0	0	0	0	0	(501,778)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	(7,132)	0	0	0	0	0	0	0	0	0	0	(7,132)	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**	(508,910)	0	0	0	0	0	0	0	0	0	0	(508,910)	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	1,852	0	0	0	0	0	0	0	0	0	0	1,852	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):*	(803,916)	0	0	0	0	0	0	0	0	0	0	(803,916)	43
44	**TOTAL Special Cost Centers**	(802,064)	0	0	0	0	0	0	0	0	0	0	(802,064)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(2,874,177)	0	0	0	0	0	0	0	0	0	0	(2,874,177)	45

Facility Name & ID Number St Andrew Life Center # 0044776 Report Period Beginning: 7/1/2011 Ending: 6/30/2012

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
Resurrection Health Care	100	Resurrection Senior Services	Des Plaines	See PG 6-Supp attached		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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	$ 651,081	Resurrection Health Care Corporation	100.00%	$ 651,081	$	1
2	V	30	Depreciation	87,720	Resurrection Health Care Corporation	100.00%	87,720		2
3	V	32	Interest	202,082	Resurrection Health Care Corporation	100.00%	202,082		3
4	V	39	Pharmacy	222,263	Resurrection Health Care Corporation	100.00%	222,263		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			$ 1,163,146			$ 1,163,146	$ *	14

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

Facility Name & ID Number St Andrew Life Center # 0044776 Report Period Beginning: 7/1/2011 Ending: 6/30/2012

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	Resurrection Health Care Corp.	100 %	Resurrection Senior Services	Chicago	Provena-Resurrection	Chicago	Health Care	1
2					Resurrection Universit	Oak Park	Health Care	2
3					Holy Family Health Ca	Des Plaines	Health Care	3
4					Holy Family Medical C	Des Plaines	Health Care	4
5					Mt. Loretto Nursing H	Amsterdam	Senior Living	5
6					Our Lady of the Resur	Chicago	Health Care	6
7					Provena Care & Home	Mokena	Health Care	7
8					Provena Health	Frankfort	Health Care	8
9					Provena Home Health,	Mokena	Health Care	9
10					Provena Hospitals	Frankfort	Health Care	10
11					Provena Laverna Terr	Mokena	Health Care	11
12					Provena Self Insurance	Frankfort	Insurance	12
13					Provena Senior Servic	Mokena	Health Care	13
14					Provena Family Servic	Broadview	Health Care	14
15					Resurrection Ambulat	Chicago	Health Care	15
16					Resurrection Developn	Des Plaines	Fundraising	16
17					Resurrection Health C	Des Plaines	Health Care	17
18					Resurrection Home He	Morton Grove	Home Care	18
19					Resurrection Medical (	Chicago	Health Care	19
20					Resurrection Medical (	Chicago	Fundraising	20
21					Resurrection Ministrie	Castleton	Parent Corp	21
22					Resurrection Nursing I	Castleton	Senior Living	22
23					Resurrection Services	Chicago	Health Care	23
24					Saint Francis Hospital	Evanston	Health Care	24
25					Saint Francis Hospital	Evanston	Fundraising	25
26					Saint Mary and Elizab	Chicago	Health Care	26
27					St. Joseph Hospital	Chicago	Health Care	27
28								28
29								29
30								30

Facility Name & ID Number St Andrew Life Center # 0044776 Report Period Beginning: 7/1/2011 Ending: 6/30/2012

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	John Walton - Thru 10/31/11	BOD						1
2	Sr. Donna Marie Wolowicki thru 9/30/11	BOD						2
3	Nicola Byrne thru 12/16/11	BOD						3
4	Demetrios Kouzios thru 12/1/11	BOD						4
5	Connie March - effective 11/1/11	BOD						5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number St Andrew Life Center # 0044776 Report Period Beginning: 7/1/2011 Ending: 6/30/2012

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

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

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

Facility Name & ID Number St Andrew Life Center # 0044776 Report Period Beginning: 7/1/2011 Ending: 6/30/2012

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Resurrection Health Care
Street Address: 100 North River Road
City / State / Zip Code: Des Plaines, Illinois 60016
Phone Number: (847) 813-3719
Fax Number: (847) 813-3786

	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	Cost Charged per TB	1	1	$ 651,081	$	1	$ 651,081	1
2	30	Depreciation	Cost Charged per TB	1	1	87,720		1	87,720	2
3	32	Interest	Cost Charged per TB	1	1	202,082		1	202,082	3
4	39	Pharmacy	Cost Charged per TB	1	1	222,263		1	222,263	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					$ 1,163,146	$		$ 1,163,146	25

Facility Name & ID Number St Andrew Life Center # 0044776 Report Period Beginning: 7/1/2011 Ending: 6/30/2012

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	Allocated from Home Office						$	$			$ 202,082	1
2												2
3												3
4												4
5												5
	Working Capital											
6	N/A											6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 202,082	9
	B. Non-Facility Related*											
10	N/A											10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$ 202,082	15

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

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

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

Facility Name & ID Number St Andrew Life Center # 0044776 Report Period Beginning: 7/1/2011 Ending: 6/30/2012

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 (		$	7

Real Estate Tax History

Real Estate Tax Bill for Calendar Year		
	2007	8
	2008	9
	2009	10
	2010	11
	2011	12

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

	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 St Andrew Life Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0044776

CONTACT PERSON REGARDING THIS REPORT Michael Gordon, Business Unit CFO

TELEPHONE (708) 478-7911 FAX #: (708) 478-5387

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.	Facility is a not-for-profit and does not pay real estate taxes for the ICF main property.		$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 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 St Andrew Life Center # 0044776 Report Period Beginning: 7/1/2011 Ending: 6/30/2012

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 155,990 B. General Construction Type: Exterior Brick Frame Masonary Number of Stories 6

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).

Assisted Living & Independent Living

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

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

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Use	436,304	2000	$ 2,600,000	1
2					2
3	TOTALS	436,304		$ 2,600,000	3

Facility Name & ID Number St Andrew Life Center # 0044776 Report Period Beginning: 7/1/2011 Ending: 6/30/2012

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	55		2000	1951	$ 936,802	$ 24,021	39	$ 24,021	$	$ 364,874	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2000	5,782	289	20	289		3,469	9
10	Various			2001	72,830	2,887	5-15	2,887		70,490	10
11	Various			2002	244,065	15,913	10 - 15	15,913		169,193	11
12	Various			2003	30,221	935	15 - 40	935		8,527	12
13	Various			2004	276,024	15,243	5 - 20	15,243		120,052	13
14	Various			2005	402,121	32,892	5 - 20	32,892		247,701	14
15	Various			2006	33,042	3,321	5-15	3,321		21,711	15
16	Various			2007	5,777,727	290,042	5 - 20	290,042		1,594,412	16
17	Various			2008	115,262	9,245	10 - 20	9,245		41,601	17
18											18
19	Com Ed Smart Ideas Program - Lighting Retrofit			2009	6,473	647	10	647		1,618	19
20	Com Ed Smart Ideas Program - Lighting Retrofit			2009	4,451	445	10	445		1,113	20
21	New Compressor for Walk-in Cooler			2009	4,350	362	12	362		906	21
22	Srvc Call; Repair & Water Pipe Replacement - Inside Wall			2009	11,740	587	20	587		1,468	22
23	8 Drop in Wiring Installations - Rms 101,102,122,365 & 467			2009	9,966	498	20	498		1,744	23
24											24
25	Fireproof Ceiling in Trash Chute Room			2010	2,500	208	12	208		521	25
26	Shades and Installation			2010	5,236	748	7	748		1,870	26
27	Com Ed Smart Ideas Program - Lighting Retrofit			2010	842	84	10	84		211	27
28	4th Floor Memory Care Unit Furnishings			2010	10,935	729	15	729		1,822	28
29											29
30	Engineering & Sprinkler Design for 2013 Compliance			2011	7,248	242	15	242		242	30
31	Painting of 3rd & 4th Floor Common Areas- Hallways			2011	10,000	1,000	5	1,000		1,000	31
32	Engineering & Sprinkler Design for 2013 Compliance			2011	7,248	145	25	145		145	32
33	Replace Programmer installed in Boiler #3			2011	3,654	183	10	183		183	33
34	Install new Vinyl flring;5th Flr Hallwys,3 dining rms& Kitchenette			2011	6,394	320	10	320		320	34
35	Install new Vinyl flring;3 & 4th Flr incl Dining rm Nrs Station			2011	28,064	1,403	10	1,403		1,403	35
36	Install new Vinyl flring;5th Flr Hallwys,3 dining rms & Kitchenette			2011	36,727	1,836	10	1,836		1,836	36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

Facility Name & ID Number St Andrew Life Center # 0044776 Report Period Beginning: 7/1/2011 Ending: 6/30/2012

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			$	$		$	$	$	37
38	Install new Vinyl flooring; 3rd & 4th Flr- incldng Dining rm Nrs Station	2011	1,305	65	10	65		65	38
39	Install new Vinyl flooring; 3rd & 4th Flr - including Dining rm Nrs Stati	2011	36,405	1,820	10	1,820		1,820	39
40	Install new Vinyl flooring; 3rd & 4th Flr - including Dining rm Nrs Stati	2011	6,070	303	10	303		303	40
41	Install new Vinyl flooring; 3rd & 4th Flr - including Dining rm Nrs Stati	2011	1,240	62	10	62		62	41
42	Painting of 3rd & 4th Floor Common Areas- Hallways	2011	10,000	1,000	5	1,000		1,000	42
43	Replace the Chapel Doors	2011	5,863	147	20	147		147	43
44	Install new Door Operator	2011	6,800	453	15	453		680	44
45	Access door installation on the upper level in Chapel	2011	2,838	189	15	189		284	45
46	Replace Main Drain & Water Supply Lines; 1st & 5th FL South	2011	7,675	307	25	307		460	46
47									47
48	Replace 12 tubes in Boiler #2	2012	4,500	225	10	225		225	48
49	5th FLNorth Rms 536-568 Responder 4000 Audio/Visual Nrs	2012	13,403	670	10	670		670	49
50	Replace 2 Grease Traps	2012	5,980	199	15	199		199	50
51	5th FLNorth Rms 536-568 Responder 4000 Audio/Visual Nrs	2012	13,403	670	10	670		670	51
52	5th FLNorth Rms 536-568 Responder 4000 Audio/Visual Nrs	2012	11,489	574	10	574		574	52
53	Emergency Masonry & Roof Repairs	2012	12,775	639	10	639		639	53
54	Emergency Masonry & Roof Repairs	2012	25,549	1,277	10	1,277		1,277	54
55	Install Fire Doors - 5th Floor Sun Room	2012	1,780	44	20	44		44	55
56	Landscaping - Removal of 6 dead trees, branches & debris	2012	6,800	340	10	340		340	56
57	Landscaping- Tree Pruning along North & West side property	2012	2,800	140	10	140		140	57
58	Replace Water Heater for Laundry Room	2012	4,550	228	10	228		228	58
59									59
60									60
61									61
62									62
63	Rounding Diff			3		3			63
64									64
65	Adjs to Financial statement depreciation	2012				(356,739)	(356,739)	2,277,132	65
66									66
67	Allocated from Home Office	2012		87,720		87,720			67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 8,230,929	$ 501,300		$ 144,561	$ (356,739)	$ 4,945,391	70

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

Facility Name & ID Number St Andrew Life Center # 0044776 Report Period Beginning: 7/1/2011 Ending: 6/30/2012

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	$ 1,370,703	$ 111,669	$ 111,669	$	5 - 25	$ 800,721	71
72	Current Year Purchases	30,262	1,478	1,478		5 - 15	1,478	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,400,965	$ 113,147	$ 113,147	$		$ 802,199	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)	$ 12,231,894	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 614,447	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 257,708	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (356,739)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 5,747,590	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	Non-care bldg & improvements-01	$ 2,666,530	$ 124,072	$ 1,653,563	86
87	Non-care bldg equipment-01	507,976	2,515	484,050	87
88	Non-care bldg & improvements-03	284,062	15,686	123,548	88
89	Non-care equipment-03	17,328	1,526	14,731	89
90	Non-care equipment-2011 & 12	20,186	1,240	1,240	90
91	TOTALS	$ 3,496,082	$ 145,039	$ 2,277,132	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	$	92
93			93
94			94
95		$	95

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

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

Facility Name & ID Number St Andrew Life Center # 0044776 Report Period Beginning: 7/1/2011 Ending: 6/30/2012

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								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 ☒ X NO
16. Rental Amount for movable equipment: $ 3,947 Description: Copier Equipment - See Page 14A.
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

SALC - HFS Number 0044776
Leased Equipment
Sub-Acct 007020
FY2012

Entity#	Vendor	Sub	CK#	Amount
74 - SALC	Oce copy machine charges	90000	07020	$3,946.74
				$3,946.74

Facility Name & ID Number St Andrew Life Center # 0044776 Report Period Beginning: 7/1/2011 Ending: 6/30/2012

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
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   The CNAs that were hired were already trained.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number St Andrew Life Center # 0044776 Report Period Beginning: 7/1/2011 Ending: 6/30/2012

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		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(1)	66 hrs	3,879				66	3,879	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				222,263		222,263	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			$ 3,879		$	$ 222,263	66	$ 226,142	14

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

STATE OF ILLINOIS

Facility Name & ID Number St Andrew Life Center **#** 0044776 **Report Period Beginning:** 7/1/2011 **Ending:** 6/30/2012

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/2012 **(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	$ 47,331	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 196,762)	767,955		3
4	Supply Inventory (priced a)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	6,237		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 821,523	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	2,600,000		13
14	Buildings, at Historical Cos	10,415,239		14
15	Leasehold Improvements, at Historical Cos	110,749		15
16	Equipment, at Historical Cos	2,553,916		16
17	Accumulated Depreciation (book methods)	(5,701,075)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	48,120		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(46,516)		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)**	$ 9,980,433	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 10,801,956	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 48,926	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	217,450		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	3,058		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to Affiliates	7,631,006		36
37	Other Accrued Expenses	290,538		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 8,190,978	$	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)**	$ 8,190,978	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,610,978	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 10,801,956	$	48

***(See instructions.)**

Facility Name & ID Number St Andrew Life Center **#** 0044776 **Report Period Beginning:** 7/1/2011 **Ending:** 6/30/2012

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,299,741	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,299,741	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(758,921)	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 Equipmen		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (758,921)	17
	B. Transfers (Itemize):		
18			18
19	Net Intercompany Transfers	70,158	19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 70,158	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,610,978	24 *

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

Facility Name & ID Number St Andrew Life Center # 0044776 Report Period Beginning: 7/1/2011 Ending: 6/30/2012

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	$ 4,942,433	1
2	Discounts and Allowances for all Level	(1,044,672)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,897,761	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	44,470	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 44,470	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	9,370	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	14,539	18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	17,195	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 41,104	23
	D. Non-Operating Revenue		
24	Contributions	1,350	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,350	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc. Income - See Page 19A	2,770,216	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,770,216	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,754,901	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,729,131	31
32	Health Care	1,449,696	32
33	General Administration	2,231,759	33
	B. Capital Expense		
34	Ownership	972,647	34
	C. Ancillary Expense		
35	Special Cost Centers	222,263	35
36	Provider Participation Fee	104,410	36
	D. Other Expenses (specify):		
37	Assisted / Independent Living Expenses	803,916	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,513,822	40
41	**Income before Income Taxes (line 30 minus line 40)****	(758,921)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (758,921)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,449,895	44
45	Private Pay - Net Inpatient Revenue	2,536,536	45
46	Medicare - Net Inpatient Revenue	(44,199)	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3	$ 3,942,232	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? N/A 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.**

Schedule XVII - Income Statement: Line 28 - Other Revenue Detail:

Description	Amount	Notes on Cost Report Treatmen
Revenue from Assets Released for Operation	25,368	Not income - Fund Transfer only
Admin - Rental Income Independent Living	809,269	See Cost Offsets on Page 5A
Admin - Rental Income Assisted Living	1,199,286	See Cost Offsets on Page 5A
Admin - Rental Income Memory Unit	623,257	See Cost Offsets on Page 5A
Spir - Chapel Collections	5,256	Revenue Offset on Page 5A
Miscellaneous Revenue	107,780	Revenue Offset on Page 5A
To Line 28	2,770,216	

Facility Name & ID Number St Andrew Life Center # 0044776 Report Period Beginning: 7/1/2011 Ending: 6/30/2012

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	2,056	2,230	$ 89,348	$ 40.07	1
2	Assistant Director of Nursing					2
3	Registered Nurses	11,222	12,259	422,648	34.48	3
4	Licensed Practical Nurses	13,972	15,624	377,427	24.16	4
5	CNAs & Orderlies	53,840	59,840	800,476	13.38	5
6	CNA Trainees					6
7	Licensed Therapist	58	66	3,879	58.77	7
8	Rehab/Therapy Aides					8
9	Activity Director	2,061	2,242	47,795	21.32	9
10	Activity Assistants	4,583	5,033	84,500	16.79	10
11	Social Service Workers	1,950	2,115	52,757	24.94	11
12	Dietician	106	114	2,684	23.54	12
13	Food Service Supervisor	1,981	2,230	66,056	29.62	13
14	Head Cook	6,553	7,215	93,465	12.95	14
15	Cook Helpers/Assistants	20,722	22,658	237,710	10.49	15
16	Dishwashers					16
17	Maintenance Workers	10,018	11,254	204,806	18.20	17
18	Housekeepers	16,249	18,666	220,175	11.80	18
19	Laundry	4,393	4,926	51,123	10.38	19
20	Administrator	1,667	2,037	92,358	45.34	20
21	Assistant Administrator					21
22	Other Administrative	13,410	14,792	254,359	17.20	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director	116	121	13,193	109.03	27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Ca MDS/Quality	291	313	12,816	40.95	32
33	Other(specify) Religious Wages	2,809	3,010	83,827	27.85	33
34	TOTAL (lines 1 - 33)	168,057	186,745	$ 3,211,402 *	$ 17.20	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				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$		49

C. CONTRACT NURSES

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

Facility Name & ID Number St Andrew Life Center # 0044776 Report Period Beginning: 7/1/2011 Ending: 6/30/2012

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Mary L. Hobbs	Administrator	0	$ 37,371
Alpana Patel	Administrator	0	19,268
Norma B. Wilson	Administrator	0	35,719
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 92,358

B. Administrative - Other

Description	Amount
Management Exp - Fees Paid To Home Office (See Sch. VII)	$ 651,081
TOTAL (agree to Schedule V, line 17, col. 3)	$ 651,081
(Attach a copy of any management service agreement)	

C. Professional Services

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

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 34,526
Unemployment Compensation Insurance	9,150
FICA Taxes	187,774
Employee Health Insurance	525,205
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Life Insurance	6,226
Employee Disability Insurance	14,389
Employee Dental Insurance	14,552
Employee Retirement	193,960
Tuition Reimb and other Assistance benefits	15,870
Adjustment amount allocated to Assisted Living	(257,522)
Internal Benefit allocation to Assisted Living	(166,327)
TOTAL (agree to Schedule V, line 22, col.8)	$ 577,803

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

Description	Line #	Amount
N/A		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
Life Service Network of ILL	2,201
Niles Chamber of Comm	210
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 2,411

G. Schedule of Travel and Seminar**

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

**See instructions.

Facility Name & ID Number St Andrew Life Center # 0044776 Report Period Beginning: 7/1/2011 Ending: 6/30/2012

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

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

Facility Name & ID Number St Andrew Life Center # 0044776 Report Period Beginning: 7/1/2011 Ending: 6/30/2012

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 **LSN $2201**

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

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

(5) Have you properly capitalized all major repairs and equipment purchases **Yes**
What was the average life used for new equipment added during this period **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expens and the location of this expense on Sch. V. $ **19,564** Line **10(2)**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departme during this cost report period. $ **104,410**
This amount is to be recorded on line 42 of Schedule V

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

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

(14) Is a portion of the building used for any function other than long term care services f the patient census listed on page 2, Section B **Yes-Assisted Living** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attac a schedule which explains how all related costs were allocated to these function

(15) Indicate the cost of employee meals that has been reclassified to employee benefi on Schedule V. $ **0** Has any meal income been offset agains related costs? **Yes** Indicate the amount $ **9,370**

(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 fc residents? **No** If YES, please indicate the amount of income earned from such program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients **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? **Yes**
f. Has the cost for commuting or other personal use of autos been adjuste out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing 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 o out of Schedule V? **Yes**

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

#74, SALC ,ST ANDREW LIFE CENTER, HFS #0044776
Non ICF Overhead Adjustment on Page 5A
Fiscal Year Ended 6/30/2012
Attachement to Question 14, Page 23

Schedule XX
Supplemental
Page 23A

Total Days	54,524
ICF Days	18,501
Non-ICF Days	36,023
Ratio of Non ICF days to total	0.66068

Overhead costs		Non ICF Ratio	Non ICF Costs	Amt net of direct offset	
Dietary	**438,964**	66.068%	290,015	290,015	
Food Purchase	**424,046**	66.068%	280,159	280,159	
Housekeeping	**210,805**	66.068%	139,275	139,275	
Depreciation	**759,486**	66.068%	501,778	356,739	< Less 145039 Direct
Laundry	**75,042**	66.068%	49,579	49,579	
Heat and Other Utilities	**183,025**	66.068%	120,921	120,921	
Maintenance	**397,249**	66.068%	262,455	262,455	
Benefits - line 22	**1,110,394**				
Add: Amt in ac 90150 as part of direct offset	**207,709**				
Total Benefits	**1,318,103**	35.296%	465,231	257,522	
		S-T OH Offse		1,756,666	s-t

Non -ICF Direct Wages	582,841
Add Non-ICF Overhead Wages	550,640
total non ICF Salaries	1,133,481
total wages	3,211,402
ratio	35.30%
Overhead salary (Lines 1 - 6)	833,442
NON- ICF Ratio	66.07%
Allocation of OH Salary	550,640

Add:	
Direct Wages	582,841
Supplies	12,771
Other Costs	208,304

Total direct Offset	803,916
Total Offsets w/ OH	**2,560,582**