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)

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

I. IDPH License ID Number: 0044784

Facility Name: St Benedict Nursing & Rehab

Address: 6930 West Touhy Avenue (Number) Niles (City) 60714 (Zip Code)

County: Cook

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

HFS ID Number:

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

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
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 AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/1/2011 to 6/30/2012 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) 10/30/2012 (Date)
(Type or Print Name) Mike Volante
(Title) System Director - Reimbursement

Paid Preparer

(Signed) 10/30/2012 (Date)
(Print Name and Title) Patrick Szajkovics, Senior Consultant
(Firm Name & Address) Strategic Reimbursement, Inc., 360 W. Butterfield Road, Suite 310, Elmhurst, IL 60126
(Telephone) (630) 530-7100 Fax # (630) 530-7106

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

Facility Name & ID Number St Benedict Nursing & Rehab # 0044784 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	99	Skilled (SNF)	99	36,234	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	99	TOTALS	99	36,234	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	4,066	8,482	10,446	22,994	8
9	SNF/PED					9
10	ICF	2,914	7,877	719	11,510	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	6,980	16,359	11,165	34,504	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.23%

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 [X] NO [ ] If YES, enter number of beds certified 99 and days of care provided 8,161

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

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

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

Facility Name & ID Number St Benedict Nursing & Rehab # 0044784 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				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	436,431	64,834	866	502,131		502,131	(143,885)	358,246			1
2	Food Purchase		308,131		308,131		308,131	(86,508)	221,623			2
3	Housekeeping	240,663	1,682	1,055	243,400		243,400	(68,335)	175,065			3
4	Laundry	133,952	48,876		182,828		182,828	(8,063)	174,765			4
5	Heat and Other Utilities			161,517	161,517		161,517	(45,346)	116,171			5
6	Maintenance	123,037	6,433	161,515	290,985		290,985	(81,694)	209,291			6
7	Other (specify):*											7
8	TOTAL General Services	934,083	429,956	324,953	1,688,992		1,688,992	(433,831)	1,255,161			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	2,303,223	146,881	64,155	2,514,259		2,514,259	(32,740)	2,481,519			10
10a	Therapy	555,592	1,942	20,465	577,999		577,999		577,999			10a
11	Activities	147,325	15,922	624	163,871		163,871		163,871			11
12	Social Services	136,760	12,572	5,007	154,339		154,339		154,339			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,142,900	177,317	90,251	3,410,468		3,410,468	(32,740)	3,377,728			16
	C. General Administration											
17	Administrative	133,584		969,928	1,103,512		1,103,512		1,103,512			17
18	Directors Fees											18
19	Professional Services											19
20	Dues, Fees, Subscriptions & Promotions			6,431	6,431		6,431		6,431			20
21	Clerical & General Office Expenses	569,633	17,691	(173,318)	414,006		414,006	178,047	592,053			21
22	Employee Benefits & Payroll Taxes			1,431,765	1,431,765		1,431,765	(57,254)	1,374,511			22
23	Inservice Training & Education											23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			632	632		632		632			25
26	Insurance-Prop.Liab.Malpractice			219,631	219,631		219,631		219,631			26
27	Other (specify):*											27
28	TOTAL General Administration	703,217	17,691	2,455,069	3,175,977		3,175,977	120,793	3,296,770			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,780,200	624,964	2,870,273	8,275,437		8,275,437	(345,778)	7,929,659			29

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

Facility Name & ID Number St Benedict Nursing & Rehab #0044784 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			479,061	479,061		479,061	(134,496)	344,565			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			126,639	126,639		126,639	(126,639)				32
33	Real Estate Taxes			5,210	5,210		5,210	(5,210)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			10,035	10,035		10,035		10,035			35
36	Other (specify):*											36
37	TOTAL Ownership			620,945	620,945		620,945	(266,345)	354,600			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		782,783		782,783		782,783	32,740	815,523			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			295,875	295,875		295,875		295,875			42
43	Other (specify):* Asstd/Ind Living	110,621		47,988	158,609		158,609	(158,609)				43
44	TOTAL Special Cost Centers	110,621	782,783	343,863	1,237,267		1,237,267	(125,869)	1,111,398			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,890,821	1,407,747	3,835,081	10,133,649		10,133,649	(737,992)	9,395,657			45

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

Facility Name & ID Number St Benedict Nursing & Rehab # 0044784 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	(2,912)	1		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(8,063)	4		8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(126,639)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(20,651)	21		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(579,727)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (737,992)		$	30

BHF USE ONLY								
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (737,992)		37

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

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

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

St Benedict Nursing & Rehab

ID# 0044784

Report Period Beginning: 7/1/2011

Ending: 6/30/2012

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Misc. Income	$ (27,702)	21	1
2	Offset Assisted / Indep Living Wages & Other Exp.	(158,609)	43	2
3	Offset Empl benefits for Assisted / Indep Living	(57,254)	22	3
4	Offset Dietary costs for Assisted / Indep Living	(140,973)	1	4
5	Offset Food costs for Assisted / Indep Living	(86,508)	2	5
6	Offset Housekeeping for Assisted / Indep Living	(68,335)	3	6
7	Offset Utilities Exp for Assisted / Indep Living	(45,346)	5	7
8	Offset Maintenance for Assisted / Indep Living	(81,694)	6	8
9	Offset Depreciation for Assisted / Indep Living	(134,496)	30	9
10	Offset Charity Care exp. Credit Adj from Hospital	226,400	21	10
11	Offset Real Estate Taxes	(5,210)	33	11
12				12
13	Lab Expense - Reclass Outside Services	(31,680)	10	13
14	X-Ray Expense - Reclass Outside Services	(1,060)	10	14
15	Lab and X-Ray Reclass Exp to Ancillary Line	32,740	39	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**	(579,727)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number St Benedict Nursing & Rehab **#** 0044784 **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	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	(143,885)	0	0	0	0	0	0	0	0	0	0	(143,885)	1
2	Food Purchase	(86,508)	0	0	0	0	0	0	0	0	0	0	(86,508)	2
3	Housekeeping	(68,335)	0	0	0	0	0	0	0	0	0	0	(68,335)	3
4	Laundry	(8,063)	0	0	0	0	0	0	0	0	0	0	(8,063)	4
5	Heat and Other Utilities	(45,346)	0	0	0	0	0	0	0	0	0	0	(45,346)	5
6	Maintenance	(81,694)	0	0	0	0	0	0	0	0	0	0	(81,694)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(433,831)	0	0	0	0	0	0	0	0	0	0	(433,831)	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	(32,740)	0	0	0	0	0	0	0	0	0	0	(32,740)	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**	(32,740)	0	0	0	0	0	0	0	0	0	0	(32,740)	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	178,047	0	0	0	0	0	0	0	0	0	0	178,047	21
22	Employee Benefits & Payroll Taxes	(57,254)	0	0	0	0	0	0	0	0	0	0	(57,254)	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**	120,793	0	0	0	0	0	0	0	0	0	0	120,793	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(345,778)	0	0	0	0	0	0	0	0	0	0	(345,778)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number St Benedict Nursing & Rehab # 0044784 **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	(134,496)	0	0	0	0	0	0	0	0	0	0	(134,496)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(126,639)	0	0	0	0	0	0	0	0	0	0	(126,639)	32
33	Real Estate Taxes	(5,210)	0	0	0	0	0	0	0	0	0	0	(5,210)	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**	(266,345)	0	0	0	0	0	0	0	0	0	0	(266,345)	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	32,740	0	0	0	0	0	0	0	0	0	0	32,740	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):*	(158,609)	0	0	0	0	0	0	0	0	0	0	(158,609)	43
44	**TOTAL Special Cost Centers**	(125,869)	0	0	0	0	0	0	0	0	0	0	(125,869)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(737,992)	0	0	0	0	0	0	0	0	0	0	(737,992)	45

Facility Name & ID Number St Benedict Nursing & Rehab # 0044784 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	Administration	$ 969,928	Resurrection Health Care Corporation	100.00%	$ 969,928	$	1
2	V	30	Depreciation	143,237	Resurrection Health Care Corporation	100.00%	143,237		2
3	V	32	Interest Expense	126,639	Resurrection Health Care Corporation	100.00%	126,639		3
4	V	39	Pharmacy	782,783	Resurrection Health Care Corporation	100.00%	782,783		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			$ 2,022,587			$ 2,022,587	$ *	14

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

Facility Name & ID Number St Benedict Nursing & Rehab # 0044784 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 Insuranc	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 Benedict Nursing & Rehab # 0044784 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 to 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 Benedict Nursing & Rehab # 0044784 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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 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 Benedict Nursing & Rehab # 0044784 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 office or parent organization costs? (See instructions.) YES [X] NO [ ]

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

Name of Related Organization: Resurrection Health Care
Street Address: 100 North River Road
City / State / Zip Code: Des Plaines, 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	Administration	Cost Charged per TB	1	1	$ 969,928	$	1	$ 969,928	1
2	30	Depreciation	Cost Charged per TB	1	1	143,237		1	143,237	2
3	32	Interest Expense	Cost Charged per TB	1	1	126,639		1	126,639	3
4	39	Pharmacy	Cost Charged per TB	1	1	782,783		1	782,783	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					$ 2,022,587	$		$ 2,022,587	25

Facility Name & ID Number St Benedict Nursing & Rehab # 0044784 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**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Allocated from Home Office						$	$			$ 126,639	1
2												2
3												3
4												4
5												5
	Working Capital											
6	N/A											6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 126,639	9
	B. Non-Facility Related*											
10	Interest Income Offset										(126,639)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (126,639)	14
15	TOTALS (line 9+line14)						$	$			$	15

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

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

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

Facility Name & ID Number St Benedict Nursing & Rehab # 0044784 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 6.	$	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 LTC 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 Benedict Nursing & Rehab COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0044784

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 LTC main property.	$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 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 Benedict Nursing & Rehab # 0044784 Report Period Beginning: 7/1/2011 Ending: 6/30/2012

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

Independent Living Units

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number St Benedict Nursing & Rehab # 0044784 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	99		2000	1991	$ 4,247,413	$ 108,840	35	$ 108,840	$	$ 1,254,047	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2000	1,095,075	43,803	35	43,803		628,941	9
10	Various			2000	30,917		7 - 10			30,917	10
11	Various			2001	273,061	16,933	7 - 20	16,933		194,649	11
12	Various			2002	34,410	2,371	10 - 20	2,371		24,412	12
13	Various			2003	3,328	166	20	166		1,581	13
14	Various			2004	14,267	828	10 - 20	828		6,925	14
15	Various			2005	190,455	13,017	5 - 15	13,017		117,852	15
16	Various			2006	86,586	8,606	5 - 15	8,606		51,533	16
17	Various			2008	1,284	64	20	64		289	17
18											18
19	10 Gallon Clipper Duo			2011	2,999	300	5	300		300	19
20	Install Belbien on Elevator Panels in 2 Cabs			2011	6,244	312	10	312		312	20
21	Emergency repair to Main Kitchen Refrigerator			2011	4,542	454	5	454		454	21
22	Install Shredded Hrdwood Mulch to Planting Beds & Trees			2011	3,400	567	3	567		567	22
23	Replace Carpet-Common Areas Flr.1 & 2, Incl Adm Offcs			2011	22,143	2,214	5	2,214		2,214	23
24	Replace Carpet-Common Areas Flr.1 & 2, Incl Adm Offcs			2011	11,267	1,127	5	1,127		1,127	24
25	Replace Carpet-Common Areas Flr.1 & 2, Incl Adm Offcs			2011	9,423	942	5	942		942	25
26	Replace Carpet-Common Areas Flr.1 & 2, Incl Adm Offcs			2011	27,131	2,713	5	2,713		2,713	26
27	Emergency Security Door System Repairs			2011	2,016	101	10	101		101	27
28	Install Wood Handrails & Matching Base in New Hallway			2011	4,761	159	15	159		159	28
29	Flooring Replacementof Back hallway - Dock Vinyl			2011	8,817	441	10	441		441	29
30	Removal of Radiator for new Patio Entrance			2011	4,229	141	15	141		141	30
31											31
32	Carpet for Dining Rooms			2012	5,677	568		568		568	32
33	Install Wood Handrails & Matching Base in New Pt.Hallway			2012	3,581	119		119		119	33
34	Security Systems for Front & Rear Access			2012	10,776	539		539		539	34
35	L & M to Install Oak Fire Rated Door			2012	2,260	75		75		75	35
36	L & M to Install Solid Oak Core Door			2012	1,780	59		59		59	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number St Benedict Nursing & Rehab # 0044784 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	L & M to Install Solid Oak Double French Doors	2012	$ 5,360	$ 179	15	$ 179	$	$ 179	37
38	Replace Exterior Lighting & Run New Water Fountain Line	2012	2,260	56	20	56		56	38
39	Furnish & Install a Folding Door	2012	7,725	386	10	386		386	39
40	New Carpeting in Various Offices	2012	3,891	389	5	389		389	40
41	New Carpeting in Various Offices	2012	1,776	178	5	178		178	41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66	Financial Statement Depreciation Adjustment								66
67	Home office allocation					143,237	143,237		67
68	Assisted / Indepdent Living Offset					(134,496)	(134,496)		68
69									69
70	TOTAL (lines 4 thru 69)		$ 6,128,854	$ 206,647		$ 215,388	$ 8,741	$ 2,323,165	70

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

Facility Name & ID Number St Benedict Nursing & Rehab # 0044784 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	$ 2,098,923	$ 129,105	$ 129,105	$	3 - 20	$ 1,350,875	71
72	Current Year Purchases	1,462	73	73		10	73	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 2,100,385	$ 129,178	$ 129,178	$		$ 1,350,948	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)	$ 11,139,501	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 335,825	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 344,566	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 8,741	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,674,113	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 & Eqp Fixed Assets	$ 2,310,359	$ 134,496	$ 1,031,507	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 2,310,359	$ 134,496	$ 1,031,507	91

G. Construction-in-Progress

	Description	Cost	
92	Accrued FA per TB	$ 9,218	92
93			93
94			94
95		$ 9,218	95

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

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

Facility Name & ID Number St Benedict Nursing & Rehab # 0044784 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:	N/A			$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. N/A
   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: $ 10,035 Description: Copiers and Medical Equipment - See Page 14A for a breakdown.
    (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.

St. Benedict Nursing and Rehab Center

Provider Number: 0044784

FYE: 6/30/2012

Attachment to Schedule XII, Line 16- Equipment Rental Cost

Sub Acct .7020

Equipment	Amount
Copiers & Printers	6,483
Sub-total Admin acct 9000-	6,483
Misc. Medical Equipment	3,552
Other Medical Equipment	-
Sub-Total Medical Equipment acct 90140-	3,552
Total - Rental Equipment Costs	10,035

Facility Name & ID Number St Benedict Nursing & Rehab # 0044784 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 Benedict Nursing & Rehab

STATE OF ILLINOIS
0044784 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	10A (1 & 3)	2326 hrs	$ 103,270	156	$ 9,900	$	2,482	$ 113,170	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist	10A (1 & 3)	1179 hrs	59,031				1,179	59,031	3
4	Licensed Physical Therapist	10A (1 & 3)	4012 hrs	171,207	155	9,688		4,167	180,895	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				782,783		782,783	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): COTA	10A (1 & 3)			16	862		16	862	12
13	Other (specify):									13
14	TOTAL			$ 333,508	327	$ 20,450	$ 782,783	7,844	$ 1,136,741	14

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

STATE OF ILLINOIS

Facility Name & ID Number St Benedict Nursing & Rehab **#** 0044784 **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	$ 313,195	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 232,834)	1,757,402		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	46,964		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,117,561	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	11,148,719		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)	(3,674,113)		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): Board Designated Funds	8,111,103		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 15,585,709	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 17,703,270	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 543,622	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation	148,410		34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to RMC	(3,130,762)		36
37	Due to Third Party Payors	(14,123)		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ (2,452,853)	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ (2,452,853)	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 20,156,123	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 17,703,270	$	48

***(See instructions.)**

Facility Name & ID Number St Benedict Nursing & Rehab # 0044784 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**	$ 18,843,675	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 18,843,675	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,292,273	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 1,292,273	17
	B. Transfers (Itemize):		
18	**Equity Transfers**	20,175	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 20,175	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 20,156,123	24 *

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

Facility Name & ID Number St Benedict Nursing & Rehab # 0044784 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	$ 12,697,376	1
2	Discounts and Allowances for all Levels	(4,202,664)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,494,712	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,420,154	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,420,154	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	2,912	14
15	Telephone, Television and Radio	753	15
16	Rental of Facility Space	18,550	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	8,063	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 30,278	23
	D. Non-Operating Revenue		
24	Contributions	3,930	24
25	Interest and Other Investment Income***	449,898	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 453,828	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc Income	26,950	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 26,950	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 11,425,922	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,688,992	31
32	Health Care	3,410,468	32
33	General Administration	3,175,977	33
	B. Capital Expense		
34	Ownership	620,945	34
	C. Ancillary Expense		
35	Special Cost Centers	782,783	35
36	Provider Participation Fee	295,875	36
	D. Other Expenses (specify):		
37	Assisted / Independent Living Direct Costs	158,609	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,133,649	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,292,273	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,292,273	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,289,308	44
45	Private Pay - Net Inpatient Revenue	5,475,580	45
46	Medicare - Net Inpatient Revenue	1,729,824	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 8,494,712	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.**

Facility Name & ID Number St Benedict Nursing & Rehab # 0044784 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	1,487	1,730	$ 81,861	$ 47.32	1
2	Assistant Director of Nursing					2
3	Registered Nurses	26,737	29,916	1,057,889	35.36	3
4	Licensed Practical Nurses	8,498	9,456	238,886	25.26	4
5	CNAs & Orderlies	74,113	82,258	1,098,193	13.35	5
6	CNA Trainees					6
7	Licensed Therapist	7,265	7,908	347,805	43.98	7
8	Rehab/Therapy Aides	8,943	9,916	217,001	21.88	8
9	Activity Director	1,926	2,131	57,586	27.02	9
10	Activity Assistants	6,696	7,584	92,993	12.26	10
11	Social Service Workers	1,426	1,925	53,557	27.82	11
12	Dietician	1,087	1,258	42,338	33.66	12
13	Food Service Supervisor	1,695	1,931	56,625	29.32	13
14	Head Cook	8,864	10,076	138,943	13.79	14
15	Cook Helpers/Assistants	17,556	19,437	201,098	10.35	15
16	Dishwashers					16
17	Maintenance Workers	4,867	5,489	123,526	22.50	17
18	Housekeepers	18,473	20,680	250,875	12.13	18
19	Laundry	10,319	11,485	123,724	10.77	19
20	Administrator	1,922	2,431	133,584	54.95	20
21	Assistant Administrator					21
22	Other Administrative	18,854	21,668	357,007	16.48	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director	54	54	7,851	145.39	27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: MDS COORD	3,886	4,270	160,103	37.49	32
33	Other(specify) Religious Staff	1,589	1,797	49,376	27.48	33
34	TOTAL (lines 1 - 33)	226,257	253,400	$ 4,890,821 *	$ 19.30	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 Benedict Nursing & Rehab # 0044784 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	$ 39,452
Bernadine Ladra	Administrator	0	7,557
Anthony T.Madl	Administrator	0	86,575
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 133,584

B. Administrative - Other

Description	Amount
Management Exp - Fees Paid To Home Office (See Sch. VII)	$ 969,928
TOTAL (agree to Schedule V, line 17, col. 3)	$ 969,928
(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	$ 48,907
Unemployment Compensation Insurance	13,036
FICA Taxes	345,289
Employee Health Insurance	686,970
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Life Insurance	8,831
Employee Disability Insurance	19,558
Employee Dental Insurance	20,670
Employee Retirement	265,945
Tuition Reimbursement	16,998
Employee Assistance and other benefits	5,561
Disallowed Assisted Living Empl Benefits	(57,254)
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,374,511

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

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
Life Services Network	3,144
Allscripts	2,315
IDPH License	972
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 6,431

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)	$

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number St Benedict Nursing & Rehab # 0044784 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		$		$	$	$	$	$	$	$	$	$

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. **Life Services Network $3144**

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

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **14,296** Line **10 (2)**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **295,875**
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? **Yes. See Pg 23A** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **2,912**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100%**
d. Have vehicle usage logs been maintained? **Adequate records are maintained.**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **0**

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

(18) Have all costs which do not relate to the provision of long term care been adjusted 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

#84, SBNRC, ST BENEDICT NURSING & REHAB CENTER, HFS #0044784
Non LTC Overhead Offsets for Offset on Page 5A
Fiscal Year 2012
Attachment to Page 23, Question 14

Schedule XX.
Supplemental
Page 23A

Assisted / Independent Living Days	9,687
Total Skilled & Intermediate Days	34,504
Total Days	44,191
Ratio of Assisted/Indep Living days to total	0.28075

Sch V. Ln.	Overhead costs	Sch V, Col 4 Expense	Ratio	Costs Adj		Salary Only
1.0	Dietary	**502,131**	28.075%	140,973		436431
2.0	Food Purchase	**308,131**	28.075%	86,508		0
3.0	Housekeeping	**243,400**	28.075%	68,335		240663
4.0	Laundry - N/A See Revenue Offset made	-	28.075%	-		0
5.0	Heat and Other Utilities	**161,517**	28.075%	45,346		0
6.0	Maintenance	**290,985**	28.075%	81,694		123037
22.0	Benefits	**1,431,765**	7.351%	105,242		0
	Less: $40321 + 7667 Direct Benefits			(47,988)	57,254	0
30.0	Depreciation	**479,061**	28.075%	134,496		0
	Total OH Offsets			614,606		800131

Non LTC Wages Direct	110,621
Add Non-LTC Overhead Wages	224,637
Total Non LTC Wages	335,258
total wages	4,561,016
ratio	7.35%
Overhead salary	800,131
NON- ICF Ratio	28.08%
Non-LTC OH Wages	224,637

Add:	
Direct Wages	110,621
Supplies	0
Other Costs	47,988
Total direct Offset	158,609
Total Offsets w/ OH	**773,215**