		FOR BHF USE				

LL1

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: 0044792

Facility Name: Villa Scalabrini Nursing & Rehab

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

County: Cook

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

HFS ID Number:

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

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Raj Shah Telephone Number: (630) 530-7100 Ext 107
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/2011 to 06/30/2012 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)	12/7/2012 (Date)
	(Type or Print Name)	Michael Volante
	(Title)	System Director - Reimbursement
Paid Preparer	(Signed)	12/6/2012 (Date)
	(Print Name and Title)	Raj Shah Senior Reimbursement Consultant
	(Firm Name & Address)	Strategic Reimbursement, Inc. 360 W. Butterfield Road, Suite 310, Elmhurst, IL 60126
	(Telephone)	(630) 530-7100 Ext 107 Fax # (630) 530-7106

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

Facility Name & ID Number Villa Scalabrini Nursing & Rehab # 0044792 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	171	Skilled (SNF)	171	62,586	1
2		Skilled Pediatric (SNF/PED)			2
3	82	Intermediate (ICF)	82	30,012	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	253	TOTALS	253	92,598	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	26,956	6,668	17,083	50,707	8
9	SNF/PED					9
10	ICF	19,650	8,790	1,572	30,012	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	46,606	15,458	18,655	80,719	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.17%

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

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

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

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

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

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

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 03/01/2000 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 171 and days of care provided 50,707

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 06/30/2012 Fiscal Year: 06/30/2012

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

Facility Name & ID Number Villa Scalabrini Nursing & Rehab # 0044792 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

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	604,846	95,804	339	700,989		700,989		700,989			1
2	Food Purchase		581,275		581,275		581,275	(9,378)	571,897			2
3	Housekeeping	293,496	98,355	1,337	393,188		393,188		393,188			3
4	Laundry	187,168	76,584	4,619	268,371		268,371	(14,287)	254,084			4
5	Heat and Other Utilities			279,623	279,623		279,623		279,623			5
6	Maintenance	173,525	21,301	423,416	618,242		618,242		618,242			6
7	Other (specify):*											7
8	**TOTAL General Services**	1,259,035	873,319	709,334	2,841,688		2,841,688	(23,665)	2,818,023			8
	B. Health Care and Programs											
9	Medical Director			21,700	21,700		21,700		21,700			9
10	Nursing and Medical Records	5,304,123	375,407	58,172	5,737,702		5,737,702	(57,669)	5,680,033			10
10a	Therapy	763,210	25,080	110,274	898,564		898,564		898,564			10a
11	Activities	174,442	32,692	860	207,994		207,994	(280)	207,714			11
12	Social Services	297,434	17,270	1,867	316,571		316,571		316,571			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	6,539,209	450,449	192,873	7,182,531		7,182,531	(57,949)	7,124,582			16
	C. General Administration											
17	Administrative			1,709,790	1,709,790		1,709,790	117,574	1,827,364			17
18	Directors Fees											18
19	Professional Services											19
20	Dues, Fees, Subscriptions & Promotion			14,508	14,508		14,508	280	14,788			20
21	Clerical & General Office Expenses	950,104	21,053	(152,759)	818,398		818,398	108,240	926,638			21
22	Employee Benefits & Payroll Taxes			2,583,007	2,583,007		2,583,007		2,583,007			22
23	Inservice Training & Education											23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			646	646		646		646			25
26	Insurance-Prop.Liab.Malpractice			229,511	229,511		229,511		229,511			26
27	Other (specify):*											27
28	**TOTAL General Administration**	950,104	21,053	4,384,703	5,355,860		5,355,860	226,094	5,581,954			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	8,748,348	1,344,821	5,286,910	15,380,079		15,380,079	144,480	15,524,559			29

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

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

Facility Name & ID Number Villa Scalabrini Nursing & Rehab #0044792 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

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			838,780	838,780		838,780		838,780			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			221,467	221,467		221,467	(1,692)	219,775			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			69,087	69,087		69,087		69,087			35
36	Other (specify):*											36
37	TOTAL Ownership			1,129,334	1,129,334		1,129,334	(1,692)	1,127,642			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,634,801		1,634,801		1,634,801	57,669	1,692,470			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			637,704	637,704		637,704		637,704			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		1,634,801	637,704	2,272,505		2,272,505	57,669	2,330,174			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	8,748,348	2,979,622	7,053,948	18,781,918		18,781,918	200,457	18,982,375			45

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

Facility Name & ID Number Villa Scalabrini Nursing & Rehab # 0044792 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

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	(9,378)	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	(14,287)	4		8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(1,692)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	225,814			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 200,457		$	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))**	$ 200,457		37

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

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

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

Villa Scalabrini Nursing & Rehab

ID# 0044792

Report Period Beginning: 07/01/2011

Ending: 06/30/2012

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Admin -Other Rev	$ (11,884)	17	1
2	charity care CR from Res Hosp-Reported As -ve exp	248,400	21	2
3	Marketing Exp	(10,702)	21	3
4				4
5	Administrator's Salary	129,458	17	5
6	Administrator's Salary	(129,458)	21	6
7				7
8	Lab Exp Reclass	(57,669)	10	8
9	Lab Exp Reclass	57,669	39	9
10				10
11	Dues Exp grouping correction	(280)	11	11
12	Dues Exp grouping correction	280	20	12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	225,814		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Villa Scalabrini Nursing & Rehab # 0044792 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

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

	Operating Expenses A. General Services	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)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(9,378)	0	0	0	0	0	0	0	0	0	0	(9,378)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(14,287)	0	0	0	0	0	0	0	0	0	0	(14,287)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(23,665)	0	0	0	0	0	0	0	0	0	0	(23,665)	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	(57,669)	0	0	0	0	0	0	0	0	0	0	(57,669)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(280)	0	0	0	0	0	0	0	0	0	0	(280)	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**	(57,949)	0	0	0	0	0	0	0	0	0	0	(57,949)	16
	C. General Administration													
17	Administrative	117,574	0	0	0	0	0	0	0	0	0	0	117,574	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	280	0	0	0	0	0	0	0	0	0	0	280	20
21	Clerical & General Office Expenses	108,240	0	0	0	0	0	0	0	0	0	0	108,240	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	226,094	0	0	0	0	0	0	0	0	0	0	226,094	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	144,480	0	0	0	0	0	0	0	0	0	0	144,480	29

Facility Name & ID Number Villa Scalabrini Nursing & Rehab # 0044792 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,692)	0	0	0	0	0	0	0	0	0	0	(1,692)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(1,692)	0	0	0	0	0	0	0	0	0	0	(1,692)	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	57,669	0	0	0	0	0	0	0	0	0	0	57,669	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	57,669	0	0	0	0	0	0	0	0	0	0	57,669	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	200,457	0	0	0	0	0	0	0	0	0	0	200,457	45

Facility Name & ID Number Villa Scalabrini Nursing & Rehab # 0044792 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

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	See Attached PG6-Supp		See Attached PG6-Supp		

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	$ 1,709,790	Resurrection Health Care	100.00%	$ 1,709,790	$	1
2	V	30	Depreciation	252,761	Resurrection Health Care	100.00%	252,761		2
3	V	32	Interest	221,467	Resurrection Health Care	100.00%	221,467		3
4	V	39	Pharmacy	1,634,793	Resurrection Health Care	100.00%	1,634,793		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			$ 3,818,811			$ 3,818,811	$ *	14

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

STATE OF ILLINOIS

Page 6-Supplemental

Facility Name & ID Number Villa Scalabrini Nursing & Rehab # 0044792 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

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. (RHCC)	100	Resurrection Senior Services	Chicago	Provena-Resurrectio	Chicago	Health Care	1
2					Resurrection Univers	Oak Park	Health Care	2
3					Holy Family Health C	Des Plaines	Health Care	3
4					Holy Family Medical	Des Plaines	Health Care	4
5					Mount Loretto Nursi	Amsterdam	Senior Living	5
6					Our Lady of the Resu	Chicago	Health Care	6
7					Provena Care & Hom	Mokena	Health Care	7
8					Provena Health	Frankfort	Health Care	8
9					Provena Home Healt	Mokena	Health Care	9
10					Provena Hospitals	Frankfort	Health Care	10
11					Provena Laverna Te	Mokena	Health Care	11
12					Provena Self-Insurar	Frankfort	Insurance	12
13					Provena Senior Servi	Mokena	Health Care	13
14					Proviso Family Srvcs	Broadview	Health Care	14
15					Resurrection Ambula	Chicago	Health Care	15
16					Resurrection Develo	Des Plaines	Fundraising	16
17								17
18					Resurrection Health	Des Plaines	Health Care	18
19					Resurrection Home	Morton Grove	Home Care	19
20					Resurrection Medica	Chicago	Health Care	20
21					Resurrection Medica	Chicago	Fundraising	21
22					Resurrection Ministr	Castleton	Parent Corp	22
23					Resurrection Nursin	Castleton	Senior Living	23
24								24
25					Resurrection Service	Chicago	Health Care	25
26					Saint Francis Hospita	Evanston	Health Care	26
27					Saint Francis Hospita	Evanston	Fundraising	27
28					Saints Mary and Eliz	Chicago	Health Care	28
29					St. Joseph Hospital	Chicago	Health Care	29
30								30

Facility Name & ID Number Villa Scalabrini Nursing & Rehab # 0044792 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

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 Villa Scalabrini Nursing & Rehab # 0044792 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

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	
					Compensation Received From Other	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	
	Name	Title	Function	Ownership Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
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 Villa Scalabrini Nursing & Rehab # 0044792 Report Period Beginning: 07/01/2011 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

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

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

	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				$	$		$ 1,709,790	1
2	30	Depreciation							252,761	2
3	32	Interest							221,467	3
4	39	Pharmacy							1,634,793	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					$	$		$ 3,818,811	25

Facility Name & ID Number Villa Scalabrini Nursing & Rehab # 0044792 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

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	Interest Exp						$	$			$ 221,467	1
2	Less: Interest Income										(1,692)	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 219,775	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$ 219,775	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 Villa Scalabrini Nursing & Rehab # 0044792 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2011 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	N/A	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Villa Scalabrini Nursing & Rehab COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0044792

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

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 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 Villa Scalabrini Nursing & Rehab # 0044792 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

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

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

3. Current Period Amortization: N/A 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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Residence Care	696,960	2,000	$ 1,500,000	1
2					2
3	TOTALS	696,960		$ 1,500,000	3

Facility Name & ID Number Villa Scalabrini Nursing & Rehab # 0044792 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

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	253		2000		$ 7,520,069	$ 250,248	7-30	$ 250,248	$	$ 3,099,773	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10	Various			2001	22,045	241	10-10	241		22,045	10
11	Various			2002	19,214	461	7-20	461		18,960	11
12	Various			2003	60,584	4,245	5-15	4,245		49,623	12
13	Various			2004	104,281	7,801	5-25	7,801		75,160	13
14	Various			2005	125,857	10,597	5-15	10,597		86,730	14
15	Various			2006	2,268,283	127,048	5-25	127,048		831,625	15
16	Various			2007	193,245	15,366	5-25	15,366		113,330	16
17	Various			2008	174,564	16,781	3-20	16,781		76,847	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

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Villa Scalabrini Nursing & Rehab # 0044792 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

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	ComEd Smart Ideas Program - Lighting Retrofit	2009	$ 16,167	$ 1,617	10	$ 1,617	$	$ 4,042	37
38	Vinyl Tile - 1st floor	2009	4,709	471	10	471		1,177	38
39	Carpet - 1st floor Corridor North	2009	11,584	2,317	5	2,317		5,792	39
40	Remove wallpaper + paint in hallways/rooms	2009	11,150	2,230	5	2,230		5,575	40
41	ComEd Smart Ideas Program - Lighting Retrofit	2009	4,150	415	10	415		1,038	41
42	Breezeway Glass Replacement	2009	7,789	519	15	519		1,298	42
43	ComEd Smart Ideas Program - Lighting Retrofit	2009	553	55	10	55		138	43
44	ComEd Smart Ideas Program - Lighting Retrofit	2009	20,105	2,010	10	2,010		5,026	44
45	RELOCATE 140-TON MCQUAY CONDENSING UNIT	2009	24,985	2,499	10	2,499		8,745	45
46	FIRE PROTECTION FOR 6 COOLERS	2009	7,533	753	10	753		2,636	46
47	Drawings & specs for a new generator	2009	80,604	16,121	5	16,121		56,423	47
48	Survey of 11 facilities for electrical equipment	2009	4,000	667	3	667		4,000	48
49	REMODEL CHARLES WALTON ROOM	2009	6,449	430	15	430		1,505	49
50	CHAPEL SOUND SYSTEM	2009	7,118	712	10	712		2,491	50
51	PRINTS WITH DOUBLE MAT & FRAME PRESENTATION	2009	1,480	148	10	148		518	51
52	OAK & PECAN FLOORING W/INSTALLATION	2009	2,413	241	10	241		845	52
53	REMODEL CHARLES WALTON ROOM	2009	6,000	400	15	400		1,400	53
54	REPLACE 1 HEAT EXCHANGER BUNDLE ON DOMESTIC HOT WATER HEAT	2009	8,840	1,768	5	1,768		6,188	54
55	REMOVAL OF OLD TILE & INSTALL NEW VINYL & BASE	2009	2,750	275	10	275		963	55
56	SURVEY OF FACILITY FOR ELECTRICAL EQUIPMENT	2009	4,031	672	3	672		4,031	56
57									57
58	STONHARD FLOORING. REPAIR UNIT C AND G NORTH / STOP LEAKING	2010	14,900	1,490	10	1,490		2,262	58
59	COMED SMART IDEAS - MATERIAL FOR LIGHTING MODIFICATIONS	2010	10,468	1,047	10	1,047		1,596	59
60	COMED SMART IDEAS - MATERIAL FOR LIGHTING MODIFICATIONS	2010	3,327	333	10	333		579	60
61	COMED SMART IDEAS - MATERIAL FOR LIGHTING MODIFICATIONS	2010	553	55	10	55		84	61
62	INSTALL WIRING, AMPLIFIER SPEAKERS FOR MUSIC IN ALL RESIDENT DIN	2010	16,861	3,372	5	3,372		8,206	62
63	REPLACE HEAT EXCHANGER IN BOILER ROOM, INSTALL 6" BYPASS FOR S	2010	15,235	1,016	15	1,016		2,472	63
64	ELEVATOR # 2 PISTON /CYLINDER REPLACEMENT	2010	15,977	799	20	799		1,937	64
65	Furnish + Install Tone/Visual Nurse Call System	2010	1,314	188	7	188		469	65
66	Booster Heater Replacement	2010	4,041	404	10	404		1,010	66
67	Installation of new electrical feeds & boosters	2010	5,600	560	10	560		1,400	67
68	Furnish & Install Tone/Visual Nurse Call System	2010	24,961	3,566	7	3,566		8,915	68
69	Install Flooring System in Resident Bathrooms Unit F	2010	4,500	450	10	450		1,125	69
70	**TOTAL (lines 4 thru 69)**		$ **10,838,290**	$ **480,386**		$ **480,386**	$	$ **4,517,977**	70

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

Facility Name & ID Number Villa Scalabrini Nursing & Rehab # 0044792 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 10,838,290	$ 480,386		$ 480,386	$	$ 4,517,977	1
2	EMERGENCY REPAIR OF FIRE ALRAM SYSTEM	2011	2,642	132	10	132		132	2
3	EMERGENCY REPAIRS OF HEATING SYSTEM	2011	2,265	113	10	113		113	3
4	ADDITIONAL FLOOR PREP FOR HALLWAY FLOOR REPLACEMENT PROJEC	2011	5,377	269	10	269		269	4
5	REPLACE NAD INSTALL FLOORING IN COMMON AREAS HALLS WITH VINY	2011	24,012	1,201	10	1,201		1,201	5
6	RENOVATION OF INTERIOR OF 4 ELEVATORS	2011	15,772	789	10	789		789	6
7	EM ICE MACHINE REPAIR	2011	2,360	236	5	236		236	7
8	INSTALLED 4 NEW CONDENSER FAN MOTOS BLADES & RAIN SHIELDS	2011	4,901	163	15	163		163	8
9	OPTION # 1 - BOILER REPAIR NEW BURNER & INNER DOOR	2011	16,450	548	15	548		548	9
10	ENGINEERING & SPRINKLER DESIGN FOR 2013 COMPLIANCE	2011	19,581	653	15	653		653	10
11	Install Drywall to make new walls and paint walls & door frames in hallway	2011	14,500	483	15	483		483	11
12	REMOVE TILE & BASEBOARD IN HALLWAY & CLEAN UP	2011	9,500	317	15	317		317	12
13	ARCHITECTURAL SERVICE FOR LOWER LEVEL PT RENOVATIONS	2011	23,445	782	15	782		782	13
14	ENGINEERING & SPRINKLER DESIGN FOR 2013 COMPLIANCE	2011	19,580	392	25	392		392	14
15	FLOOR REPLACEMENT IN UNITS E AND D @ LOWER LEVEL - UNIT G SOUT	2011	10,643	532	10	532		532	15
16	FLOOR REPLACEMENT IN UNITS E AND D @ LOWER LEVEL - UNIT G SOUT	2011	10,670	534	10	534		534	16
17	FLOOR REPLACEMENT IN UNITS E AND D @ LOWER LEVEL - UNIT G SOUT	2011	4,832	242	10	242		242	17
18	FLOOR REPLACEMENT IN UNITS E AND D @ LOWER LEVEL - UNIT G SOUT	2011	9,483	474	10	474		474	18
19	INSTALL FIRE PUMPS ALARM SIGNAL	2011	7,265	727	10	727		1,090	19
20	INSTALL MAGNETIC DOOR HOLDERS ON MULTIPLE DOORS	2011	15,250	1,525	10	1,525		2,288	20
21	REPAIR DOORS INSTALL NEW HARDWARE & NEW CLOSER FOR 10 SETS (	2011	5,380	538	10	538		807	21
22	REPAIR OF WANDERGUARD SYSTEM IN 3 UNITS	2011	6,550	655	10	655		983	22
23	REPAIR OF WANDERGUARD SYSTEM IN 3 UNITS	2011	2,400	240	10	240		360	23
24	EMEGENCY REPAIRS IN KITCHEN PLUMBING AREA	2011	3,085	154	20	154		231	24
25	ADD SPRINKLERS TO COMMON AREA RESTROOMS @ BUILDINGS B C D &	2011	2,500	100	25	100		150	25
26	ADDITIONAL WORK NEEDED - REPLACE HEAT EXCHANGER IN BOILER RO	2011	8,136	407	20	407		610	26
27	REPLACE HEAT EXCHANGER IN BOILER ROOM - INSTALL 6 inch BYPASS F	2011	7,115	356	20	356		534	27
28	NEW SIDE ENTRY TUB FOR UNIT	2011	15,577	1,558	10	1,558		2,454	28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 11,107,560	$ 494,504		$ 494,504	$	$ 4,535,342	34

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

Facility Name & ID Number Villa Scalabrini Nursing & Rehab # 0044792 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 11,107,560	$ 494,504		$ 494,504	$	$ 4,535,342	1
2	EXTRA HARNESS 1 EACH, SMALL, MED, LARGE & EXTRA LARGE	2012	518	17	15	17		17	2
3	LANDICE REHABILITATION TREADMILL	2012	5,290	176	15	176		176	3
4	EXTRA HARNESS 1 EACH, SMALL, MED, LARGE & EXTRA LARGE	2012	1,595	53	15	53		53	4
5	UNWEIGHTING SYSTEM	2012	7,150	238	15	238		238	5
6	TOTAL BODY CYCLE	2012	4,262	142	15	142		142	6
7	TRI W-G 6 MOTORIZED BAIATRIC HI-LO PARALLEL BARS	2012	12,185	406	15	406		406	7
8	TRI W G MOTORIZED BARIATRIC HI-LO MAT TABLE - COVER & BUMPER	2012	9,095	303	15	303		303	8
9	Install new railing, mirrors, and upgrade general conditions in phy. Therapy room	2012	24,283	809	15	809		809	9
10	NEW SPRINKLER SYSTEM THERAPY ROOM	2012	7,500	150	25	150		150	10
11	INSTALLATION OF 9 STANDARD DROPS & RELOCATE 3 EXISTING	2012	6,675	222	15	222		222	11
12	INSTALLATION OF 80 GALLON ELECTRICAL WATER HEATER IN THE KITCH	2012	6,500	325	10	325		325	12
13	WINDOW TREATMENTS & CUBICLE CURTAINS FOR NEW PT ROOM	2012	18,740	937	10	937		937	13
14	ARCHITECTURAL SERVICE FOR LOWER LEVEL PT RENOVATIONS	2012	5,471	182	15	182		182	14
15	Install new doors, baseboards, and HVAC upgrade in Phy.Ther. room	2012	45,000	1,500	15	1,500		1,500	15
16	6 MECHO V MANUAL SHADES IN HALLWAY BY STATUES	2012	2,621	131	10	131		131	16
17	PHYSICAL THERAPY ROOM RENOVATIONS / PERMITS & FEES	2012	8,500	283	15	283		283	17
18	Rough in & install plumbing and fixutes in phy. Ther. Room	2012	30,000	1,000	15	1,000		1,000	18
19	SIGMA SPECTRUM NON-WIRELESS PUMP	2012	12,800	640	10	640		640	19
20	INSTALLED CONDENSING UNIT-ADDED LINE DRIER & SUCTION DRIER	2012	2,265	76	15	76		76	20
21	# 3 BOILER REPAIRS - INSTALL BURNER HEAD & BURNER DIFFUSER	2012	9,475	474	10	474		474	21
22	NEW FLOOR FINISHING IN UNITS C & G	2012	2,751	275	5	275		275	22
23									23
24	Reconciling Dep - Book Vs Fixed Asset Register	2012		736		736			24
25	Corporate Dep Allocation	2012		252,761		252,761			25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 11,330,235	$ 756,342		$ 756,342	$	$ 4,543,683	34

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

Facility Name & ID Number Villa Scalabrini Nursing & Rehab # 0044792 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

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	$ 2,911,858	$ 75,501	$ 75,501	$	5-20	$ 2,408,783	71
72	Current Year Purchases	74,696	4,901	4,901		5-10	4,901	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 2,986,554	$ 80,402	$ 80,402	$		$ 2,413,684	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Residence Care	2004 Cargo Van	2004	$ 20,358	$ 2,036	$ 2,036	$	10	$ 15,269	76
77										77
78										78
79										79
80	TOTALS			$ 20,358	$ 2,036	$ 2,036	$		$ 15,269	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 15,837,147	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 838,780	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 838,780	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 6,972,636	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

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

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

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

	Fiscal Year Ending	Annual Rent
12.	/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: $ 69,087 Description: See Attached PG14A
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Villa Scalabrini Nursing And Rehab Center

Provider Number: 0044792

FYE: 6/30/2012

Attachment to Schedule XII, Line 16- Equipment Rental Cost

Sub Acct 7020

Equipment	Amount
Copiers	17,790
Medical Equipment	50,615
Admin Other Equip	682
Total Equipment Lease Exp	69,087

Facility Name & ID Number Villa Scalabrini Nursing & Rehab # 0044792 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

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.

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10(2)	hrs	$	1,308	$ 81,601	$	1,308	$ 81,601	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							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				1,634,801		1,634,801	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): COTA	10(2)			578	31,214		578	31,214	12
13	Other (specify):									13
14	TOTAL			$	1,886	$ 112,815	$ 1,634,801	1,886	$ 1,747,616	14

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

Facility Name & ID Number Villa Scalabrini Nursing & Rehab # 0044792 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/2012 (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	$ 843,134	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable Patients (less allowance 114,000)	5,267,107		3
4	Supply Inventory (priced a)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties			8
9	Other(specify): Other Receivable	(114,836)		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 5,995,405	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	1,500,000		13
14	Buildings, at Historical Cost	9,813,915		14
15	Leasehold Improvements, at Historical Cos			15
16	Equipment, at Historical Cost	4,478,879		16
17	Accumulated Depreciation (book methods	(6,897,235)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	78,000		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(75,400)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify)			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 8,898,159	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 14,893,564	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 296,181	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,197,810		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	1,508		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	(1,753,332)		36
37	Other Accrued Exp	211,889		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ (45,944)	$	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)**	$ (45,944)	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 14,939,508	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 14,893,564	$	48

*(See instructions.)

Facility Name & ID Number Villa Scalabrini Nursing & Rehab # 0044792 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 14,350,645	1
2	Restatements (describe)		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 14,350,645	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	588,863	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)**	$ 588,863	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 14,939,508	24 *

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

Facility Name & ID Number Villa Scalabrini Nursing & Rehab # 0044792 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

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	$ 29,019,888	1
2	Discounts and Allowances for all Levels	(9,734,533)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 19,285,355	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	9,378	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	14,287	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 23,665	23
	D. Non-Operating Revenue		
24	Contributions	11,551	24
25	Interest and Other Investment Income***	1,692	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 13,243	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	From Sch 19A	48,518	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 48,518	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 19,370,781	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,841,688	31
32	Health Care	7,182,531	32
33	General Administration	5,355,860	33
	B. Capital Expense		
34	Ownership	1,129,334	34
	C. Ancillary Expense		
35	Special Cost Centers	1,634,801	35
36	Provider Participation Fee	637,704	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 18,781,918	40
41	**Income before Income Taxes (line 30 minus line 40)****	588,863	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 588,863	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 7,240,251	44
45	Private Pay - Net Inpatient Revenue	4,889,595	45
46	Medicare - Net Inpatient Revenue	7,155,509	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3	$ 19,285,355	49

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

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

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

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

Villa Scalbrini Nursing and Rehab Center

Medicaid Provider Number: 0044792

FYE 6/30/2012

Attchment to Line 28, Schedule XVII - Other Revenue

Description	Amount	Remark
Net Assets Released from restrictions	15,875	Not an income
Net Assets Released from restrictions	6,101	Not an income
Admin-Rental Revenue	14,658	Inter company transfer. Not subject to o
Admin - Other Revenue	11,884	Offset on Page 5A
Total - Other Revenue	48,518	

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

Interest Income	1,692	
Interest Expenses	221,467	PG4
Interest income offset - lower of two	1,692	

Facility Name & ID Number Villa Scalabrini Nursing & Rehab # 0044792 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,890	2,163	$ 103,853	$ 48.01	1
2	Assistant Director of Nursing	1,848	2,131	93,497	43.87	2
3	Registered Nurses	75,957	84,328	2,936,497	34.82	3
4	Licensed Practical Nurses	6,689	7,740	201,251	26.00	4
5	CNAs & Orderlies	144,831	160,165	2,080,751	12.99	5
6	CNA Trainees					6
7	Licensed Therapist	11,086	12,041	494,253	41.05	7
8	Rehab/Therapy Aides	16,480	18,349	372,840	20.32	8
9	Activity Director	1,685	1,913	40,770	21.31	9
10	Activity Assistants	11,305	12,656	137,754	10.88	10
11	Social Service Workers	1,635	1,826	49,456	27.08	11
12	Dietician	4,106	4,638	89,890	19.38	12
13	Food Service Supervisor	2,842	3,082	68,430	22.20	13
14	Head Cook	9,703	11,160	162,523	14.56	14
15	Cook Helpers/Assistants	25,297	27,342	289,112	10.57	15
16	Dishwashers					16
17	Maintenance Workers	8,102	8,980	178,712	19.90	17
18	Housekeepers	21,686	24,330	264,648	10.88	18
19	Laundry	15,063	16,622	204,009	12.27	19
20	Administrator	1,914	2,163	129,458	59.85	20
21	Assistant Administrator					21
22	Other Administrative	25,389	28,002	471,971	16.85	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Ca mds care plan coor	8,132	8,967	320,096	35.70	32
33	Other(specify) Chaplain	2,132	2,480	58,577	23.62	33
34	TOTAL (lines 1 - 33)	397,772	441,078	$ 8,748,348 *	$ 19.83	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

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

Facility Name & ID Number: Villa Scalabrini Nursing & Rehab # 0044792 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Kaplan, Michael	Administrator		$ 129,458
Refer to PG 5A for Reclass)			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 129,458

B. Administrative - Other

Description	Amount
Management Fees	$ 1,709,790
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 1,709,790

C. Professional Services

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

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 84,321
Unemployment Compensation Insurance	22,263
FICA Taxes	629,530
Employee Health Insurance	1,294,453
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Retirement	465,678
Group Life Ins	15,170
Emp. Disability Ins	33,048
Tuition Reimb.	29,007
Emp Assistance	9,537
TOTAL (agree to Schedule V, line 22, col.8)	$ 2,583,007

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check (Indicate # of checks performed)	
Patient Background Checks	
AHIMA	175
All Script	2,315
Illinois Council	4,260
Life Serv	7,758
Social work consult	280
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 14,788

G. Schedule of Travel and Seminar**

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

**See instructions.

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 repor **No**
If YES, give association name and amount **N/A**

(3) Did the nursing home make political contributions or payments to a politic 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 tl 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 perioc **5-10 Yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expen: and the location of this expense on Sch. V. $ **25,447** Line **10(b)**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departme during this cost report period. $ **637,704**
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 **No** 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 $ **9,378**

(16) Travel and Transportatior
a. Are there costs included for out-of-state travel **No**
If YES, attach a complete explanation
b. Do you have a separate contract with the Department to provide medical transportation fo residents? **No** If YES, please indicate the amount of income earned from such 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 oth times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjuste out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? **No**
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firn **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 service performed been attached to this cost report **N/A**
Attach invoices and a summary of services for all architect and appraisal fee