

		FOR OHF USE				

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**2001  
STATE OF ILLINOIS  
DEPARTMENT OF PUBLIC AID  
FINANCIAL AND STATISTICAL REPORT FOR  
LONG-TERM CARE FACILITIES  
(FISCAL YEAR 2001)**

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.

<p><b>I. IDPH Facility ID Number:</b> <u>0045435</u></p> <p><b>Facility Name:</b> <u>St James Manor &amp; Villa</u></p> <p><b>Address:</b> <u>1251 East Richton Road</u> <u>Crete</u> <u>60417</u>  <small>Number City Zip Code</small></p> <p><b>County:</b> <u>Will</u></p> <p><b>Telephone Number:</b> <u>(708)672-6700</u> <b>Fax #</b> <u>(708)672-4939</u></p> <p><b>IDPA ID Number:</b> <u>36-4276604-001</u></p> <p><b>Date of Initial License for Current Owners:</b> <u>04/16/2000</u></p> <p><b>Type of Ownership:</b></p> <table border="0"> <tr> <td><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input checked="" type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td><b>IRS Exemption Code</b> <u>501(c)(3)</u></td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>Richard D. Truesdale</u> <b>Telephone Number:</b> <u>(630) 243-2244</u></p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	<b>IRS Exemption Code</b> <u>501(c)(3)</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>July 1, 2000</u> to <u>June 30, 2001</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td data-bbox="1144 673 1281 828">Officer or Administrator of Provider</td> <td data-bbox="1281 673 1921 747">(Signed) _____  <small>(Date)</small> <u>November 9, 2001</u>            (Type or Print Name) <u>Dianne Strutyński</u></td> </tr> <tr> <td data-bbox="1144 747 1281 828"></td> <td data-bbox="1281 747 1921 828">(Title) <u>Executive director/ administrator</u></td> </tr> <tr> <td data-bbox="1144 828 1281 1039">Paid Preparer</td> <td data-bbox="1281 828 1921 1039">(Signed) _____  <small>(Date)</small>            (Print Name and Title) _____            (Firm Name &amp; Address) _____            (Telephone) <u>( )</u> Fax # ( )</td> </tr> </table> <p align="center"><b>MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</b></p>	Officer or Administrator of Provider	(Signed) _____ <small>(Date)</small> <u>November 9, 2001</u> (Type or Print Name) <u>Dianne Strutyński</u>		(Title) <u>Executive director/ administrator</u>	Paid Preparer	(Signed) _____ <small>(Date)</small> (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>( )</u> Fax # ( )
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																													
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Officer or Administrator of Provider	(Signed) _____ <small>(Date)</small> <u>November 9, 2001</u> (Type or Print Name) <u>Dianne Strutyński</u>																														
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Paid Preparer	(Signed) _____ <small>(Date)</small> (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>( )</u> Fax # ( )																														

**St James Manor & Villa  
0045435  
Change of Ownership  
July 1, 2000  
June 30, 2001**

Please note effective July 1,2001, the ownership of St. James Manor changed.  
The new ID numbers are as follows:

IDPH Facility ID number            0045435

IDPA ID number                        35112441004

Facility Name & ID Number St James Manor & Villa

# 0045435 Report Period Beginning: July 1, 2000 Ending: June 30, 2001

**III. STATISTICAL DATA**

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

	1	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	<u>110</u>	Skilled (SNF)	<u>110</u>	<u>40,150</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	<u>71</u>	Sheltered Care (SC)	<u>71</u>	<u>25,915</u>	5
6		ICF/DD 16 or Less			6
7	<u>181</u>	TOTALS	<u>181</u>	<u>66,065</u>	7

B. Census-For the entire report period.

	1 Level of Care	3 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		2 Public Aid Recipient	Private Pay	4 Other		
8	SNF	<u>630</u>	<u>671</u>	<u>4,124</u>	<u>5,425</u>	8
9	SNF/PED					9
10	ICF	<u>9,233</u>	<u>17,652</u>		<u>26,885</u>	10
11	ICF/DD					11
12	SC		<u>16,978</u>		<u>16,978</u>	12
13	DD 16 OR LESS					13
14	TOTALS	<u>9,863</u>	<u>35,301</u>	<u>4,124</u>	<u>49,288</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.61%

D. How many bed-hold days during this year were paid by Public Aid? 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)  
Meals on wheels

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

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

I. On what date did you start providing long term care at this location?  
Date started 04/16/2000

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 04/16/2000 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 23 and days of care provided 4,124

Medicare Intermediary Administar

**IV. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

Is your fiscal year identical to your tax year? YES  NO

Tax Year: 06/30/2000 Fiscal Year: 06/30/2000

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

STATE OF ILLINOIS

Facility Name & ID Number **St James Manor & Villa** # **0045435** Report Period Beginning: **July 1, 2000** Ending: **June 30, 2001**

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	270,117	58,156	12,470	340,743		340,743	340,743			1
2	Food Purchase		246,952		246,952	(9,581)	237,371	237,371			2
3	Housekeeping	294,985	48,756	9,021	352,762		352,762	352,762			3
4	Laundry	7,125	1,961	34,956	44,042		44,042	44,042			4
5	Heat and Other Utilities			254,247	254,247		254,247	254,247			5
6	Maintenance	103,209	59,940	70,748	233,897		233,897	233,897			6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	<b>675,436</b>	<b>415,765</b>	<b>381,442</b>	<b>1,472,643</b>	<b>(9,581)</b>	<b>1,463,062</b>	<b>1,463,062</b>			<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			16,050	16,050		16,050	16,050			9
10	Nursing and Medical Records	2,776,759	373,831	207,651	3,358,241		3,358,241	3,358,241			10
10a	Therapy	58,942			58,942		58,942	58,942			10a
11	Activities	158,130	16,319	3,855	178,304		178,304	178,304			11
12	Social Services	55,049	90	6,063	61,202		61,202	61,202			12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>3,048,880</b>	<b>390,240</b>	<b>233,619</b>	<b>3,672,739</b>		<b>3,672,739</b>	<b>3,672,739</b>			<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	73,569	80,995	148,090	302,654		302,654	(1,710)	300,944		17
18	Directors Fees										18
19	Professional Services			86,336	86,336		86,336	86,336			19
20	Dues, Fees, Subscriptions & Promotions			19,133	19,133		19,133	(5,469)	13,664		20
21	Clerical & General Office Expenses	210,108		74,792	284,900		284,900	284,900			21
22	Employee Benefits & Payroll Taxes			631,283	631,283	128,129	759,412	759,412			22
23	Inservice Training & Education										23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			161,538	161,538	(118,548)	42,990	42,990			26
27	Other (specify):*			(65,492)	(65,492)		(65,492)	(65,492)			27
28	<b>TOTAL General Administration</b>	<b>283,677</b>	<b>80,995</b>	<b>1,055,680</b>	<b>1,420,352</b>	<b>9,581</b>	<b>1,429,933</b>	<b>(7,179)</b>	<b>1,422,754</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>4,007,993</b>	<b>887,000</b>	<b>1,670,741</b>	<b>6,565,734</b>		<b>6,565,734</b>	<b>(7,179)</b>	<b>6,558,555</b>		<b>29</b>

\*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 &amp; ID Number

St James Manor &amp; Villa

#0045435

Report Period Beginning:

July 1, 2000

Ending:

June 30, 2001

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			521,142	521,142	(14,436)	506,706	2,418	509,124			30
31	Amortization of Pre-Op. & Org.					14,436	14,436		14,436			31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			94,894	94,894		94,894		94,894			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			616,036	616,036		616,036	2,418	618,454			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	105,595	6,533	103,397	215,525		215,525		215,525			39
40	Barber and Beauty Shops		55	19,912	19,967		19,967		19,967			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			63,600	63,600		63,600		63,600			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>	105,595	6,588	186,909	299,092		299,092		299,092			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	4,113,588	893,588	2,473,686	7,480,862		7,480,862	(4,761)	7,476,101			45

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

**St James Manor & Villa**  
**0045435**  
**COST REPORT RECLASSIFICATIONS**  
**July 1, 2000**  
**June 30, 2001**

SCHEDULE V LINE #
----------------------

22	EMPLOYEE BENEFITS	<u>9,581</u>	
2	FOOD		<u>9,581</u>

To reclass cost of employee meals from raw food to employee benefits

30	Amortization of Pre-Op & Org	<u>14,436</u>	
31	Depreciation		<u>14,436</u>

To reclass amortization of goodwill on purchase of facility

22	Employee benefits	<u>118,548</u>	
26	Insurance - Prop Liab Malpractice		<u>118,548</u>

To reclass cost of workers comp insurance expense

Facility Name & ID Number St James Manor & Villa

# 0045435

Report Period Beginning: July 1, 2000

Ending: June 30, 2001

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(2,418)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	1,569	17		19
20	Contributions	141	17		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	5,469	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ 4,761		\$	30

OHF 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	2	
		Amount	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	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ 4,761		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	2	3	4
		Yes	No	Amount	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	Exceptional Care Program				44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$	47

St James Manor & Villa

ID# 0045435  
 Report Period Beginning: July 1, 2000  
 Ending: June 30, 2001

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
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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	<b>Total</b>	0	49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number St James Manor &amp; Villa

# 0045435

Report Period Beginning:

July 1, 2000

Ending:

June 30, 2001

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	0	0	0	0	0	0	0	0	0	0	0	0	8
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide 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	<b>TOTAL Health Care and Programs</b>	0	0	0	0	0	0	0	0	0	0	0	0	16
	<b>C. General Administration</b>													
17	Administrative	1,710	0	0	0	0	0	0	0	0	0	0	1,710	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	5,469	0	0	0	0	0	0	0	0	0	0	5,469	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	7,179	0	0	0	0	0	0	0	0	0	0	7,179	28
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	7,179	0	0	0	0	0	0	0	0	0	0	7,179	29



VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
St. James Manor	100	Addolorata Villa	Wheeling	Franciscan Village	Lemont	Retirement commun
		St. Joseph Home	Chicago	Franciscan Sisters of Chicago		
		Mother Theresa Home	Lemont		Lemont	Religious Congregat
		Franciscan Homes and Community Services	Crown Point, Indiana	Franciscan Sisters of Chicago Service Corp		
		George Davis Manor	Lafayette, Indiana		Homewood	Corporate mgmt
		St. Elizabeth's Health Center	Delphi, Indiana	Franciscan Communities Home Care		
		St. Clare Health Center	Otterbein, Indiana		Lemont	Home health

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	Sister services	\$ 54,667	Franciscan Sisters of Chicago	0.00%	\$ 54,667	\$	1
2	V	Therapy services	36,460	Franciscan Homes and Community Services	0.00%	36,460		2
3	V	Therapy services	5,220	Franciscan Communities Home Care	0.00%	5,220		3
4	V	Regional mgmt services	70,977	Franciscan Village, Regional office	0.00%	70,977		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		\$ 167,324			\$ 167,324	\$ *	14

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



<u>Board Member</u>	<u>Position</u>	<u>Address</u>	<u>Phone</u>	<u>Ownership in entity that conducted business with this nursing home</u>
Sister Francis Clare Radke	Chair	14700 Main Street, Lemont, IL 60439	630-257-7777	NONE
Len Wychocki	Pres/CEO	1055 W. 175th St. Homewood, IL 60430	708-647-6982	NONE
Wally Garbarczyk	Director	1055 W. 175th St. Homewood, IL 60430	708-647-6982	NONE
Sr. M. Francine Labus	Director	14700 Main Street, Lemont, IL 60439	630-257-7777	NONE
Sr. Jean Marie Toriskie	Director	4055 W. Belmont Ave, Chicago, IL 60641	773-202-0310	NONE
Barry Cesafsky	Director	914 S. Bodin, Hinsdale, IL 60521	312-782-3113	NONE
Sr. Diane Marie Collins	Director	5650 Independence Apt 3E, Oak Forest, IL 60452	708-535-9293	NONE
Chester Labus	Treasurer	1055 W. 175th St. Homewood, IL 60430	708-647-6500	NONE
Tracy Cita	Secretary	1055 W. 175th St. Homewood, IL 60430	708-647-6500	NONE

## 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									\$		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	\$ None		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 James Manor & Villa # 0045435 Report Period Beginning: July 1, 2000 Ending: ne 30, 2001

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization Franciscan Sisters of Chicago  
 Street Address 1260 Franciscan Drive  
 City / State / Zip Code Lemont, IL 60439  
 Phone Number (630)257-3987  
 Fax Number ( )

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	Sister services	Direct allocation	1	\$ 54,667	\$	1	\$ 54,667	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 54,667	\$		\$ 54,667	25

Facility Name & ID Number St James Manor & Villa # 0045435 Report Period Beginning: July 1, 2000 Ending: ne 30, 2001

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization Franciscan Homes and Community Services  
 Street Address 203 Franciscan Drive  
 City / State / Zip Code Crown Point, Indiana, 46307  
 Phone Number (219)757-6281  
 Fax Number (219)757-6236

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	39	Therapy services	Direct allocation	1	\$ 36,460	\$	1	\$ 36,460	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 36,460	\$		\$ 36,460	25

Facility Name & ID Number St James Manor & Villa # 0045435 Report Period Beginning: July 1, 2000 Ending: ne 30, 2001

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization Franciscan Communities Home Care  
 Street Address 1260 Franciscan Drive  
 City / State / Zip Code Crown Point, Indiana, 60439  
 Phone Number (630)257-3987  
 Fax Number ( )

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	39	Therapy services	Direct allocation	1	\$ 5,220	\$	1	\$ 5,220	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 5,220	\$		\$ 5,220	25

Facility Name & ID Number St James Manor & Villa # 0045435 Report Period Beginning: July 1, 2000 Ending: ne 30, 2001

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization Franciscan Village, Regional Office  
 Street Address 1260 Franciscan Drive  
 City / State / Zip Code Lemont, Illinois 60439  
 Phone Number (630)257-3987  
 Fax Number ( )

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	Regional mgmt services	Direct allocation	1	\$ 70,977	\$	1	\$ 70,977	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 70,977	\$		\$ 70,977	25

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		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
	<b>A. Directly Facility Related</b>																			
	<b>Long-Term</b>																			
1						\$	\$			\$	1									
2											2									
3											3									
4											4									
5											5									
	<b>Working Capital</b>																			
6											6									
7											7									
8											8									
9	<b>TOTAL Facility Related</b>					\$	\$			\$	9									
	<b>B. Non-Facility Related*</b>																			
10											10									
11											11									
12											12									
13											13									
14	<b>TOTAL Non-Facility Related</b>					\$	\$			\$	14									
15	<b>TOTALS (line 9+line14)</b>					\$	\$			\$ None	15									

\* 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 James Manor & Villa**# **0045435** Report Period Beginning: **July 1, 2000** Ending: **June 30, 2001****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

		<b>Important</b> , 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 2000 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 2001 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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>	\$			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. <b>TOTAL REFUND \$ _____ For 19 _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>	\$			6
7.	Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	None		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		1996	_____	8	
		1997	_____	9	
		1998	_____	10	
		1999	_____	11	
		2000	_____	12	
<b>FOR OHF USE ONLY</b>					
13	FROM R. E. TAX STATEMENT FOR 2000	\$			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.**

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Office of Health Finance at (217) 782-1630.

**2000 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME St James Manor & Villa COUNTY Will

FACILITY IDPH LICENSE NUMBER 0045435

CONTACT PERSON REGARDING THIS REPORT \_\_\_\_\_

TELEPHONE ( ) \_\_\_\_\_ FAX #: ( ) \_\_\_\_\_

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

Enter the tax index number and real estate tax assessed for 2000 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 2000.

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

**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 & 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 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number St James Manor & Villa# 0045435 Report Period Beginning:July 1, 2000 Ending:June 30, 2001

## X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 63,658 B. General Construction Type: Exterior Brick Frame Frame Number of Stories 2C. Does the Operating Entity?  (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?  (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, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

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F. Does this cost report reflect any organization or pre-operating costs which are being amortized?  YES  NO  
If so, please complete the following:1. Total Amount Incurred: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_  
3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

Nature of Costs:

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

## XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility		2000	\$ 200,000	1
2					2
3	TOTALS			\$ 200,000	3

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	181	2000	1979	\$ 4,082,381	\$ 140,772	29	\$ 140,772	\$	\$ 164,234
5		2000	1998	5,422,619	142,701	38	142,701		149,565
6									
7									
8									
<b>Improvement Type**</b>									
9	Land improvements		1988	68,448	13,690	5	13,690	(0)	15,212
10	Land improvements		1988	19,973	3,995	5	3,995	(0)	3,995
11	Land improvements		1988	48,579	6,940	7	6,940	(0)	6,940
12	Trees		2000	9,150	228	20	229	1	229
13	Facility sign		2001	20,887	522	20	522	0	522
14	Roof repair		2000	4,185	140	15	140	(1)	140
15	Phone system		2000	22,104	1,250	5	2,210	960	2,210
16	Phone system		2001	40,288	3,966	5	4,029	63	4,029
17	Water softener		2000	10,000	500	10	500		500
18	Boiler		2001	17,665	883	10	883	0	883
19									
20	Depreciation diff				50			(50)	
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
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

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
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										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										66
67										67
68										68
69										69
70	TOTAL (lines 4 thru 69)		\$ 9,766,279	\$ 315,637		\$ 316,610	\$ 973	\$ 348,459		70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 538,000	\$ 179,333	\$ 179,333	\$	3	\$ 209,075	71
72	Current Year Purchases	111,719	9,641	11,172	1,531	5	11,172	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 649,719	\$ 188,974	\$ 190,505	\$ 1,531		\$ 220,247	75

D. Vehicle Depreciation (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	Facility use	Chevy van	2000	\$ 20,093	\$ 2,095	\$ 2,009	\$ (86)	5	\$ 2,009	76
77										77
78										78
79										79
80	TOTALS			\$ 20,093	\$ 2,095	\$ 2,009	\$ (86)		\$ 2,009	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)	\$ 10,636,091	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 506,706	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 509,124	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 2,418	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 570,715	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	Elevator	\$ 2,994	92
93			93
94			94
95		\$ 2,994	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 James Manor & Villa

# 0045435

Report Period Beginning: July 1, 2000

Ending: June 30, 2001

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: NA

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 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	<b>TOTAL</b>				\$			7

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.        /2002      \$ \_\_\_\_\_  
13.        /2003      \$ \_\_\_\_\_  
14.        /2004      \$ \_\_\_\_\_

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: \_\_\_\_\_ \*

**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: \$ 94,894      Description: See attached

(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	<b>TOTAL</b>		\$	\$ None	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. James Manor & Villas

Vendor	Description	Total	Chair Oxygen, Etc	Mattresses	Peddle Chair
Advacare Systems	rental oxygen concentrator	100.00	100.00		
Advacare Systems	rental oxygen concentrator	216.66	216.66		
Advacare Systems	rental oxygen concentrator	27.19	27.19		
Advacare Systems	rental mattresses	1,736.00		1,736.00	
Averno Lake Corp	rental wheelchair, pulse oximeter, geri chair, nebulizer, aspirator	869.91	869.91		
Averno Lake Corp	rental wheelchairs	260.00			260.00
Faulner Medical	rental Broda Model 48 peddle chair	83.53			83.53
Advacare Systems	rental oxygen concentrator	309.39	309.39		
Advacare Systems	rental mattresses	2,290.00			2,290.00
Averno Lake Corp	rental wheelchair, pulse oximeter, geri chair, nebulizer, aspirator	805.00	805.00		
Advacare Systems	rental oxygen concentrator	212.52	212.52		
Advacare Systems	rental oxygen concentrator	162.52	162.52		
Advacare Systems	rental mattresses	15.70			15.70
Advacare Systems	rental mattresses	2,056.00			2,056.00
Averno Lake Corp	rental aspirators	3,195.00	3,195.00		
Averno Lake Corp	rental wheelchairs	140.00	140.00		
Averno Lake Corp	rental wheelchair, pulse oximeter, geri chair, nebulizer, aspirator	755.00	755.00		
Averno Lake Corp	rental wheelchair, pulse oximeter, geri chair, nebulizer, aspirator	945.00	945.00		
Faulner Medical	rental Broda Model 48 peddle chair	107.06			107.06
Midwest Medical	Milenum concentrator	203.52	203.52		
Advacare Systems	rental oxygen concentrator	183.36	183.36		
Averno Lake Corp	rental wheelchair, pulse oximeter, geri chair, nebulizer, aspirator	1,085.00	1,085.00		
Averno Lake Corp	rental wheelchairs	230.00	230.00		
Averno Lake Corp	rental wheelchairs	285.00	285.00		
Averno Lake Corp	rental wheelchairs	230.00	230.00		
Midwest Medical	Milenum concentrator, humidifier, cpap machine bi-pap rental	397.64	397.64		
Averno Lake Corp	rental continuous passive motion device	75.00	75.00		
Averno Lake Corp	rental wheelchair pressure pad	495.00	495.00		
Advacare Systems	rental oxygen concentrator	233.36	233.36		
Advacare Systems	rental mattresses	1,506.00		1,506.00	
Advacare Systems	rental mattresses	4,096.00		4,096.00	
Advacare Systems	rental mattresses	1,570.00		1,570.00	
Advacare Systems	rental mattresses	224.00		224.00	
Advacare Systems	rental oxygen concentrator	258.52	258.52		
Averno Lake Corp	rental wheelchairs	185.00	185.00		
Averno Lake Corp	rental wheelchairs	200.00	200.00		
Faulner Medical	rental Broda Model 48 peddle chair	250.59			250.59
Midwest Medical	Milenum concentrator, humidifier, bi-pap rental	522.00	522.00		
Advacare Systems	rental oxygen concentrator	147.94	147.94		
Averno Lake Corp	rental wheelchairs	130.00	130.00		
Averno Lake Corp	rental wheelchair, nebulizer	520.00	520.00		
Averno Lake Corp	rental wheelchairs, pressure pads	185.00	185.00		
Averno Lake Corp	rental wheelchairs	120.00	120.00		
Averno Lake Corp	rental wheelchair, aspirators	225.00	225.00		
Faulner Medical	rental Broda Model 48 peddle chair	83.53			83.53
Midwest Medical	oxygen tank rentals	800.00	800.00		
Advacare Systems	rental oxygen concentrator	283.36	283.36		
Advacare Systems	rental mattresses	4,102.00		4,102.00	
Advacare Systems	rental mattresses	4,205.00		4,205.00	
Midwest Medical	Milenum concentrator	232.00	232.00		
Averno Lake Corp	rental wheelchairs	195.00	195.00		
Faulner Medical	rental Broda Model 48 peddle chair	83.53			83.53
Advacare Systems	rental mattresses	4,627.54		4,627.54	
Advacare Systems	rental oxygen concentrator	212.52	212.52		
Advacare Systems	rental mattresses	3,645.00		3,645.00	
Averno Lake Corp	rental wheelchair, oximeter, nebulizer	2,925.00	2,925.00		
Averno Lake Corp	rental aspirator, nebulizer	155.00	155.00		
Midwest Medical	Milenum concentrator	460.91	460.91		
Averno Lake Corp	rental wheelchairs	105.00	105.00		
Averno Lake Corp	rental wheelchairs	140.00	140.00		
Faulner Medical	rental Broda Model 48 peddle chair	83.53			83.53
Midwest Medical	Milenum concentrator, oxygen tanks	906.60	906.60		
Advacare Systems	rental mattresses	231.72		231.72	
Averno Lake Corp	rental wheelchairs	950.00	950.00		
Advacare Systems	rental mattresses	3,310.00		3,310.00	
Advacare Systems	rental oxygen concentrator	143.92	143.92		
Averno Lake Corp	rental wheelchairs	190.00	190.00		
Advacare Systems	rental mattresses	5,425.00		5,425.00	
McKesson	Code alert	1,269.34			
Code alert		548.52			
<b>Total</b>		<b>63,218.43</b>	<b>21,608.84</b>	<b>39,039.96</b>	<b>751.77</b>
Advacare Systems	oxygen concentrator	150.00	150.00		
Advacare Systems	bed rental	3,769.00		3,769.00	
Averno Lake Corp	wheelchairs	869.91	869.91		
Averno Lake Corp	wheelchairs	70.00	70.00		
Advacare Systems	bed rental	2,170.00		2,170.00	
Advacare Systems	oxygen concentrator	103.13	103.13		
Averno Lake Corp	geri chair, nebulizer	1,100.00	1,100.00		
Midwest Medical Service	Rental Milenum concentrator	135.00	135.00		
Averno Lake Corp	wheelchair, geri chair, nebulizer	1,560.00	1,560.00		
Advacare Systems	oxygen concentrator	100.00	100.00		
Midwest Medical Service	Rental Milenum concentrator	120.00	120.00		
Averno Lake Corp	wheelchair, oximeter, nebulizer, aspirator	3,225.00	3,225.00		
Averno Lake Corp	wheelchair, oximeter, nebulizer, aspirator	1,510.00	1,510.00		
Advacare Systems	oxygen concentrator	100.00	100.00		
Advacare Systems	oxygen concentrator	306.30	306.30		
Advacare Systems	bed rental	2,246.00		2,246.00	
Averno Lake Corp	nebulizer, oximeter, pratt device, humidifier, geri chair	725.00	725.00		
Midwest Medical Service	Rental humidifier	67.84	67.84		
Advacare Systems	oxygen concentrator	200.00	200.00		
Averno Lake Corp	passive motion device	75.00	75.00		
Hill Rom	bed rental	452.00		452.00	
Midwest Medical Service	Humidifier, bi-pap, cpap concentrator	397.63	397.63		
Averno Lake Corp	wheelchairs, commode	485.00	485.00		
Averno Lake Corp	wheelchairs, oximeter	135.00	135.00		
Hill Rom	bed rental	1,090.00		1,090.00	
Hill Rom	bed rental	420.00		420.00	
Advacare Systems	oxygen concentrator	150.00	150.00		
Advacare Systems	bed rental	2,770.00		2,770.00	
Advacare Systems	bed rental	3,506.00		3,506.00	
Advacare Systems	oxygen concentrator	100.00	100.00		
Averno Lake Corp	wheelchairs, pressure pad	55.00	55.00		
Averno Lake Corp	wheelchairs, nebulizer, oximeter	90.00	90.00		
Midwest Medical Service	humidifier, bi-pap, concentrator, e-tank	175.00	175.00		
Averno Lake Corp	wheelchair, aspirator	365.00	365.00		
Averno Lake Corp	wheelchair, oximeter, nebulizer	380.00	380.00		
Averno Lake Corp	wheelchairs, oximeter, pressure pad	235.00	235.00		
Averno Lake Corp	wheelchairs, pressure pad, motion device	225.00	225.00		
Averno Lake Corp		1,620.00	1,620.00		
McKesson		423.00			
<b>Total</b>		<b>31,079.81</b>	<b>14,829.81</b>	<b>16,423.00</b>	<b>-</b>
<b>Grand total</b>		<b>94,298.24</b>	<b>36,438.65</b>	<b>55,462.96</b>	<b>751.77</b>

**A. TYPE OF TRAINING PROGRAM** (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION: _____</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. CLINICAL PORTION: _____</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
---	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility			
		1	2	3	4
		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	Nurse Aide 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 aides from other facilities.

\$

**D. NUMBER OF AIDES TRAINED**

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

- (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 aide 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 aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides 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 aides.

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

	Service	Schedule V Line & Column Reference	2		3		4		5		6	7	8
			Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)				
					Units	Cost							
1	Licensed Occupational Therapist		2290	hrs	\$ 57,429		\$ 13,974	\$ 6,533		2,290	\$ 77,936	1	
2	Licensed Speech and Language Development Therapist			hrs			5,400				5,400	2	
3	Licensed Recreational Therapist			hrs								3	
4	Licensed Physical Therapist		2424	hrs	48,166		19,906			2,424	68,072	4	
5	Physician Care			visits								5	
6	Dental Care			visits								6	
7	Work Related Program			hrs								7	
8	Habilitation			hrs								8	
9	Pharmacy			# of prescripts				64,117			64,117	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs								10	
11	Academic Education			hrs								11	
12	Exceptional Care Program											12	
13	Other (specify):											13	
14	<b>TOTAL</b>				\$ 105,595		\$ 39,280	\$ 70,650		4,714	\$ 215,525	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 nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name &amp; ID Number St James Manor &amp; Villa

# 0045435

Report Period Beginning: July 1, 2000

Ending: June 30, 2001

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of June 30, 2001 (last day of reporting year)

This report must be completed even if financial statements are attached.

	1	2	
	Operating	After Consolidation*	
<b>A. Current Assets</b>			
1 Cash on Hand and in Banks	\$ 172,342	\$	1
2 Cash-Patient Deposits			2
3 Accounts & Short-Term Notes Receivable-Patients (less allowance )	1,397,180		3
4 Supply Inventory (priced at )			4
5 Short-Term Investments			5
6 Prepaid Insurance			6
7 Other Prepaid Expenses	27,581		7
8 Accounts Receivable (owners or related parties)			8
9 Other(specify): Due from affiliate	30,774		9
10 <b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,627,877	\$	10
<b>B. Long-Term Assets</b>			
11 Long-Term Notes Receivable			11
12 Long-Term Investments			12
13 Land	367,037		13
14 Buildings, at Historical Cost	9,559,079		14
15 Leasehold Improvements, at Historical Cost			15
16 Equipment, at Historical Cost	712,970		16
17 Accumulated Depreciation (book methods)	(568,319)		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 (spe Goodwill)	271,960		22
23 Other(specify): CSV Life insurance	3,143		23
24 <b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 10,345,870	\$	24
25 <b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 11,973,747	\$	25

	1	2	
	Operating	After Consolidation*	
<b>C. Current Liabilities</b>			
26 Accounts Payable	\$ 660,088	\$	26
27 Officer's Accounts Payable			27
28 Accounts Payable-Patient Deposits	86,962		28
29 Short-Term Notes Payable			29
30 Accrued Salaries Payable			30
31 Accrued Taxes Payable (excluding real estate taxes)			31
32 Accrued Real Estate Taxes(Sch.IX-B)			32
33 Accrued Interest Payable			33
34 Deferred Compensation			34
35 Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>			
36 Due to affiliates	355,296		36
37			37
38 <b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,102,346	\$	38
<b>D. Long-Term Liabilities</b>			
39 Long-Term Notes Payable			39
40 Mortgage Payable			40
41 Bonds Payable			41
42 Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>			
43			43
44			44
45 <b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46 <b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,102,346	\$	46
47 <b>TOTAL EQUITY(page 18, line 24)</b>	\$ 10,871,401	\$	47
48 <b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 11,973,747	\$	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	(1,399,490)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	1,122,622	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) <b>Balance June 30, 2000</b>	11,148,264	15
16	Other (describe) <b>rounding</b>	5	16
17	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ 10,871,401	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	23
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ 10,871,401	24 *

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

Facility Name &amp; ID Number St James Manor &amp; Villa

# 0045435

Report Period Beginning: July 1, 2000

Ending: June 30, 2001

**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.**

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 5,814,670	1
2	Discounts and Allowances for all Levels	(303,642)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 5,511,028	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	183,659	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 183,659	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	24,000	12
13	Barber and Beauty Care	18,623	13
14	Non-Patient Meals	5,357	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	148,198	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	13,845	19
20	Radiology and X-Ray		20
21	Other Medical Services	156,052	21
22	Laundry	18,412	22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 384,487	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	2,198	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 2,198	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 6,081,372	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,472,643	31
32	Health Care	3,695,791	32
33	General Administration	1,420,352	33
<b>B. Capital Expense</b>			
34	Ownership	616,036	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	276,040	35
36	Provider Participation Fee		36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 7,480,862	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(1,399,490)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (1,399,490)	43

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

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

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

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

Facility Name & ID Number **St James Manor & Villa**

# **0045435**

Report Period Beginning: **July 1, 2000**

Ending:

**June 30, 2001**

**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	1,920	2,080	\$ 68,108	\$ 32.74	1
2	Assistant Director of Nursing					2
3	Registered Nurses	35,875	37,907	811,939	21.42	3
4	Licensed Practical Nurses	36,524	39,908	664,584	16.65	4
5	Nurse Aides & Orderlies	103,301	112,795	1,190,684	10.56	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	4,714	5,349	105,595	19.74	7
8	Rehab/Therapy Aides	5,283	5,822	59,145	10.16	8
9	Activity Director	1,864	1,924	38,714	20.12	9
10	Activity Assistants	13,411	13,859	119,416	8.62	10
11	Social Service Workers	3,099	3,398	55,049	16.20	11
12	Dietician					12
13	Food Service Supervisor	1,871	2,096	32,152	15.34	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,353	11,039	108,633	9.84	15
16	Dishwashers	17,509	18,657	129,331	6.93	16
17	Maintenance Workers	6,145	6,557	103,209	15.74	17
18	Housekeepers	32,432	34,039	294,985	8.67	18
19	Laundry	830	870	7,125	8.19	19
20	Administrator	1,847	2,085	73,569	35.28	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	14,633	16,322	210,107	12.87	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	2,805	3,095	41,243	13.33	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	293,416	317,802	\$ 4,113,588 *	\$ 12.94	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	\$ 11,326	1-3	35
36	Medical Director	monthly 16,050	9-3	36
37	Medical Records Consultant	monthly 3,240	10-3	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	monthly 6,064	12-3	45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 36,680		49

**C. CONTRACT NURSES**

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	440 \$ 18,364	10-3	50
51	Licensed Practical Nurses	1,418 41,469	10-3	51
52	Nurse Aides	4,370 86,194	10-3	52
53	TOTAL (lines 50 - 52)	6,228 \$ 146,027		53



**St James Manor & Villa  
0045435  
Administrative - Other  
July 1, 2000  
June 30, 2001**

Software maint - financial	6,175.00
Software maint - financial	1,325.00
Regional management services	70,976.62
Employee physicals	12,827.48
Employee physicals	697.00
Criminal background checks	1,241.35
Religious personnel	1,422.00
Sister services	54,667.00
<b>Total</b>	<b><u>149,331</u></b>



XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? yes  
If YES, give association name and amount. LSN \$7,721 ICLTC \$3,259
- (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? NA
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? YES  
What was the average life used for new equipment added during this period? 10
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 36,000 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? NA If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 63,600  
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 of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 9,581 Has any meal income been offset against related costs? \_\_\_\_\_ Indicate the amount. \$ 0
- (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. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? 100  
d. Have vehicle usage logs been maintained? YES  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? NO  
g. Does the facility transport residents to and from day training? NO  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ \_\_\_\_\_
- (17) Has an audit been performed by an independent certified public accounting firm? YES  
Firm Name: Ernst and Young The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? no If no, please explain. Not issued at this time
- (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 \$2500, have legal invoices and a summary of services performed been attached to this cost report? NA  
Attach invoices and a summary of services for all architect and appraisal fees.