

			FOR OHF USE				

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**2002**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF PUBLIC AID**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2002)**

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>0020495</u></p> <p><b>Facility Name:</b> <u>Brother James Court</u></p> <p><b>Address:</b> <u>2508 St. James Road</u> <u>Springfield</u> <u>62707</u>          Number City Zip Code</p> <p><b>County:</b> <u>Sangamon</u></p> <p><b>Telephone Number:</b> <u>(217) 544-4876</u> Fax # <u>(217) 544-4877</u></p> <p><b>IDPA ID Number:</b> <u>43/1588535004</u></p> <p><b>Date of Initial License for Current Owners:</b> <u>October 1, 1975</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>Daniel J. Call</u> <b>Telephone Number:</b> <u>(217) 793-3363</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>07/01/01</u> to <u>6/30/02</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 style="width: 20%;"><b>Officer or Administrator of Provider</b></td> <td>(Signed) _____ (Type or Print Name) <u>Brother David Sarneck</u> (Title) <u>Administrator</u></td> </tr> <tr> <td><b>Paid Preparer</b></td> <td>(Signed) _____ (Print Name and Title) <u>Daniel J. Call, CPA, Partner</u> (Firm Name &amp; Address) <u>Sikich Gardner &amp; Co, LLP</u> <u>1000 Churchill Road, Springfield, IL 62702</u> (Telephone) <u>(217) 793-3363</u> Fax # <u>(217) 793-3016</u></td> </tr> </table> <p align="right">MAIL TO: OFFICE OF HEALTH FINANCE        ILLINOIS DEPARTMENT OF PUBLIC AID        201 S. Grand Avenue East        Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	<b>Officer or Administrator of Provider</b>	(Signed) _____ (Type or Print Name) <u>Brother David Sarneck</u> (Title) <u>Administrator</u>	<b>Paid Preparer</b>	(Signed) _____ (Print Name and Title) <u>Daniel J. Call, CPA, Partner</u> (Firm Name & Address) <u>Sikich Gardner &amp; Co, LLP</u> <u>1000 Churchill Road, Springfield, IL 62702</u> (Telephone) <u>(217) 793-3363</u> Fax # <u>(217) 793-3016</u>
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Facility Name & ID Number Brother James Court

# 0020495 Report Period Beginning: 07/01/01 Ending: 6/30/02

**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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	93	Intermediate/DD	93	33,945	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	93	TOTALS	93	33,945	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		Public Aid Recipient	Private Pay	Other		
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC	33,019	407	365	33,791	12
13	DD 16 OR LESS					13
14	TOTALS	33,019	407	365	33,791	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4) 99.55%

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

1,677 (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

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 10/01/1975

J. Was the facility purchased or leased after January 1, 1978?

YES  Date \_\_\_\_\_ NO

K. Was the facility certified for Medicare during the reporting year?

YES  NO  If YES, enter number of beds certified \_\_\_\_\_ and days of care provided \_\_\_\_\_

Medicare Intermediary \_\_\_\_\_

**IV. ACCOUNTING BASIS**

ACCRAU  MODIFIED CASH\*  CASH\*

Is your fiscal year identical to your tax year YES  NO

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

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

## STATE OF ILLINOIS

Page 3

Facility Name &amp; ID Number

Brother James Court

# 0020495

Report Period Beginning:

07/01/01

Ending:

6/30/02

## 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>1</b>	<b>A. General Services</b>										
1	Dietary	295,282	19,546	1,507	316,335		316,335		316,335		1
2	Food Purchase		152,937		152,937		152,937		152,937		2
3	Housekeeping	61,957	14,476	3,235	79,668		79,668		79,668		3
4	Laundry	52,165	3,805		55,970		55,970		55,970		4
5	Heat and Other Utilities			89,024	89,024		89,024		89,024		5
6	Maintenance	110,736		115,329	226,065		226,065		226,065		6
7	Other (specify):*										7
<b>8</b>	<b>TOTAL General Services</b>	<b>520,140</b>	<b>190,764</b>	<b>209,095</b>	<b>919,999</b>		<b>919,999</b>		<b>919,999</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			2,400	2,400		2,400		2,400		9
10	Nursing and Medical Records	1,160,492	50,044	7,543	1,218,079		1,218,079		1,218,079		10
10a	Therapy			3,961	3,961		3,961		3,961		10a
11	Activities	9,579			9,579		9,579		9,579		11
12	Social Services	186,536		23,566	210,102		210,102		210,102		12
13	Nurse Aide Training			810	810		810		810		13
14	Program Transportation			14,738	14,738		14,738		14,738		14
15	Other (specify):*										15
<b>16</b>	<b>TOTAL Health Care and Programs</b>	<b>1,356,607</b>	<b>50,044</b>	<b>53,018</b>	<b>1,459,669</b>		<b>1,459,669</b>		<b>1,459,669</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	70,080		557	70,637		70,637		70,637		17
18	Directors Fees										18
19	Professional Services			59,056	59,056		59,056		59,056		19
20	Dues, Fees, Subscriptions & Promotion			4,287	4,287		4,287		4,287		20
21	Clerical & General Office Expense:	134,909	27,453	45,420	207,782		207,782	(35,092)	172,690		21
22	Employee Benefits & Payroll Tax:			453,512	453,512		453,512		453,512		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,095	1,095		1,095		1,095		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			64,735	64,735		64,735		64,735		26
27	Other (specify):*										27
<b>28</b>	<b>TOTAL General Administration</b>	<b>204,989</b>	<b>27,453</b>	<b>628,662</b>	<b>861,104</b>		<b>861,104</b>	<b>(35,092)</b>	<b>826,012</b>		<b>28</b>
<b>29</b>	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>2,081,736</b>	<b>268,261</b>	<b>890,775</b>	<b>3,240,772</b>		<b>3,240,772</b>	<b>(35,092)</b>	<b>3,205,680</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 & ID Number **Brother James Court**

#0020495

Report Period Beginning:

07/01/01

Ending:

6/30/02

## 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			196,148	196,148		196,148	142,825	338,973			30
31	Amortization of Pre-Op. & Org											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			270,000	270,000		270,000	(270,000)				34
35	Rent-Equipment & Vehicle:											35
36	Other (specify): <sup>3</sup>											36
37	<b>TOTAL Ownership</b>			466,148	466,148		466,148	(127,175)	338,973			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportatio											38
39	Ancillary Service Center:											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shop:											41
42	Provider Participation Fee			200,184	200,184		200,184		200,184			42
43	Other (specify): <sup>3</sup>											43
44	<b>TOTAL Special Cost Centers</b>			200,184	200,184		200,184		200,184			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,081,736	268,261	1,557,107	3,907,104		3,907,104	(162,267)	3,744,837			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 **Brother James Court**

# **0020495**

Report Period Beginning: **07/01/01**

Ending: **6/30/02**

**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 Program				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Room				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patient				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refund				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 Transaction				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 Retainer				22
23	Malpractice Insurance for Individual				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(35,092)	21		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employee				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (35,092)		\$	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)	(127,175)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (127,175)		36
	(sum of SUBTOTALS)			
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ (162,267)		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		X	\$		38
39						39
40	Gift and Coffee Shop		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$ NONE		47

Brother James Court

ID# 0020495

Report Period Beginning: 07/01/01

Ending: 6/30/02

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
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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	<b>Total</b>	0	49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Brother James Court# 0020495

Report Period Beginning:

07/01/01

Ending:

6/30/02**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>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>8</b>
	<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>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(35,092)	0	0	0	0	0	0	0	0	0	0	(35,092)	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>	<b>(35,092)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(35,092)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(35,092)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(35,092)</b>	<b>29</b>



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
N/A	N/A	N/A		Franciscan Brothers of the Holy Cross	Springfield	Religious Order
				Springfield Developmental Center	Springfield	Day Training Prog.
				Weber Care Corp.	Springfield	Community Living Facility

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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
	V	34 Facility Rent	\$ 270,000	Franciscan Brothers of the Holy Cros	100.00%	\$		(270,000) 1
	V	30 Depreciation		Franciscan Brothers of the Holy Cros	100.00%	142,825		142,825 2
	V							3
	V							4
	V							5
	V							6
	V							7
	V							8
	V							9
	V							10
	V							11
	V							12
	V							13
14	Total		\$ 270,000			\$ 142,825	\$ *	(127,175) 14

\* Total must agree with the amount recorded on line 34 of Schedule V1

Facility Name & ID Number Brother James Court # 0020495 Report Period Beginning: 07/01/01 Ending: 6/30/02

## 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	Brother Raphael Kreikemeier	Food Service	Head Cook	none	none	60	100.00	Salary	\$ 65,520	1.1	1
2		Supervisor									2
3	Brother Luke Morin	Resident Services	Coordinates	none	none	60	100.00	Salary	65,520	10.1	3
4		Coordinator	Resident Services								4
5	Brother Gerald Voycheck	Social Services	Social Worker	none	none	60	100.00	Salary	65,520	12.1	5
6		Director									6
7	Brother David Sarnecki	Administrator	Administrator	none	none	60	100.00	Salary	70,080	17.1	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 266,640		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 Brother James Court # 0020495 Report Period Beginning: 07/01/01 Ending: 6/30/02

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 \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$			1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number **Brother James Court** # **0020495** Report Period Beginning: **07/01/01** Ending: **6/30/02**

**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 Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	<b>A. Directly Facility Related</b>											
	<b>Long-Term</b>											
1	N/A						\$	\$			\$	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>						\$	\$			\$	15

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

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

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

Facility Name & ID Number **Brother James Court**

# **0020495** Report Period Beginning: **07/01/01** Ending: **6/30/02**

6/30/02

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

B. Real Estate Taxes

<p><b>Important</b>, please see the next worksheet, "RE_Tax". The real estate tax statement and l must accompany the cost report</p>			
1. Real Estate Tax accrual used on 2001 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 2002 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 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		\$	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	1997	8	
	1998	9	
	1999	10	
	2000	11	
	2001	12	
	<b>FOR OHF USE ONLY</b>		
	13	FROM R. E. TAX STATEMENT FOR 2001 \$	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 filec**



Facility Name & ID Number Brother James Court

# 0020495 Report Period Beginning:

07/01/01 Ending:

6/30/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 45,477 B. General Construction Type: Exterior Brick/Stone Frame Steel Number of Stories 1

C. 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 ground (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, et List entity name, type of business, square footage, and number of beds/units available (where applicable)  
NONE.

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>Facility</u>			<u>\$ Not Available</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>			<b>\$</b>	<b>3</b>

Facility Name & ID Number Brother James Court

# 0020495

Report Period Beginning:

07/01/01

Ending:

6/30/02

**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	93	1975	1975	\$ 1,003,250	\$	30	\$ 33,442	\$ 33,442	\$ 928,651	4
5		1996	1996	1,251,493		30	41,716	41,716	250,299	5
6		1997	1997	1,256,490		30	41,883	41,883	193,122	6
7										7
8										8
<b>Improvement Type**</b>										
9	New Wing - Heating & air conditioning		1997	18,883		30	629	629	3,200	9
10	Repave parking lot		1986	42,236		10			42,236	10
11	Painting/decorating		1979	2,591		5			2,591	11
12	BJC - building improvements		1980	16,233		11			16,233	12
13	BJC - building improvements		1984	21,419		10			21,419	13
14	BJC - remodeling		1987	69,555		10			69,555	14
15	BJC - water line		1987	14,120		20	706	706	9,884	15
16	Insulation		1991	9,175		15	612	612	6,677	16
17	Electrical repair		1991	613		10	20	20	613	17
18	Boiler room remodeling		1992	15,089		20	755	755	7,704	18
19	Tank removal		1992	8,500		10	425	425	8,500	19
20	Dishwashing room sewer		1992	10,680		20	534	534	5,607	20
21	BJC - Steam line		1985	14,479		10			14,479	21
22	BJC - building improvements		1975	19,600		24			19,600	22
23	BJC - Dining area remodeling		1976	34,951		10			34,951	23
24	BJC - sidewalk/patio		1976	3,545		10			3,545	24
25	BJC - Bike rink		1978	2,500		5			2,500	25
26	BJC - Air conditioning system		1979	22,876		10			22,876	26
27	BJC - site improvement		1979	1,440		26	55	55	1,298	27
28	Roof		1979	12,166		10			12,166	28
29	Roofing		1986	45,811		10			45,811	29
30	Remodeling		1988	46,656		10			46,656	30
31	Water line		1989	3,166		20	158	158	2,137	31
32	Sewage treatment plant		1990	6,411		20	321	321	3,900	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

## 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	Tank removal	1991	\$ 9,809	\$	10	\$ 409	\$ 409	\$ 9,809	37	
38	Parking lot	1992	10,452		10	1,045	1,045	10,017	38	
39	Paint restrooms	1992	230		5			230	39	
40	Boiler room remodeling	1993	15,106		20	755	755	6,804	40	
41	Repave parking lot	1994	850		10	85	85	659	41	
42	Pump	1994	734		10	73	73	599	42	
43	Air conditioner work	1994	943		10	94	94	762	43	
44	Boiler room project	1994	170,330		20	8,517	8,517	66,923	44	
45	Land improvement - trees	1996	3,470		20	174	174	1,012	45	
46	BJC - improvements	1998	15,712		30	524	524	2,270	46	
47	Water line repair	1999	3,101		10	310	310	853	47	
48	Land improvement - trees	1999	25,849		20	1,293	1,293	3,662	48	
49	Gate	1999	550		5	110	110	293	49	
50	Remodeling	1999	5,773		10	577	577	1,491	50	
51	Floor	2000	1,683		7	241	241	521	51	
52	Total Life Center	1998	122,261		30	4,075	4,075	16,641	52	
53	Leasehold improvement	1985	15,200		10			15,200	53	
54	Leasehold improvement	1986	19,507		10			19,507	54	
55	Painting	1987	9,922		3			9,922	55	
56	Steel door	1987	6,020		10			6,020	56	
57	Window replacement	1987	2,013		10			2,013	57	
58	Generator switch	1988	3,335		10			3,335	58	
59	Remodel lobby	1989	156,996	5,233	30	5,233		65,851	59	
60	Bus hut	1989	4,715	314	15	314		3,982	60	
61	Water heater	1989	6,721		10			6,721	61	
62	Transfer switch	1989	1,127		10			1,127	62	
63	Heat-energy panel	1989	8,633		10			8,633	63	
64	Leasehold improvement	1989	6,629	77	10	77		6,436	64	
65	Roof repair	1990	6,928		10			6,928	65	
66	Remodeling	1990	6,953	232	30	232		2,820	66	
67	Overhead door	1990	1,220		10			1,220	67	
68	Kitchen tanks	1990	3,089		10			3,089	68	
69	Plastering	1990	2,586		10			2,586	69	
70	TOTAL (lines 4 thru 69)		\$ 4,602,375	\$ 5,856		\$ 145,394	\$ 139,538	\$ 2,064,146	70	

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

## 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	
1	Totals from Page 12A, Carried Forward		\$ 4,602,375	\$ 5,856		\$ 145,394	\$ 139,538	\$ 2,064,146	1
2	Remodel ceiling	1990	2,970		10			2,970	2
3	Leasehold improvement	1990	26,015		10			26,015	3
4	Leasehold improvement	1991	2,141	22	10	22		2,141	4
5	Window replacement	1992	2,750	206	10	206		2,750	5
6	Cafeteria doors	1993	11,918	1,192	10	1,192		10,925	6
7	Plumbing work	1994	6,858	686	10	686		5,486	7
8	Painting	1995	3,076	308	10	308		2,153	8
9	Wall and door repair	1995	2,596	260	10	260		1,817	9
10	Door	1996	656	66	10	66		394	10
11	Roof repair	1996	5,985	598	10	598		3,591	11
12	Painting	1996	1,620		10			1,620	12
13	Furnace	1996	502	50	10	50		301	13
14	Land improvement	1996	1,385		3			1,385	14
15	Repairs	1996	10,702	103	5	103		10,291	15
16	Grip caps	1996	1,575		5			1,575	16
17	Boiler	1996	3,335	334	10	334		2,001	17
18	Bedding	1996	1,505		3			1,505	18
19	Air deflectors	1996	381		3			381	19
20	Shower	1996	259		5			259	20
21	Sewer	1996	9,387	939	10	939		4,786	21
22	Painting	1996	4,928	493	10	493		2,957	22
23	Roof repair	1997	798	80	10	80		399	23
24	Drapes	1997	4,500	900	5	900		4,500	24
25	Floor coverings	1997	1,722	172	10	172		861	25
26	Drapes - Life Center	1997	3,153	630	5	630		3,153	26
27	Floor coverings - Life Center	1997	4,422	442	10	442		2,211	27
28	Painting - Life Center	1997	8,917	892	10	892		4,459	28
29	Floor	1997	2,658	374	10	374		1,709	29
30	Alarms/Smoke detector	1998	20,108	4,022	5	4,022		13,772	30
31	Snack lounge - remodeling	1999	2,847	569	5	569		1,898	31
32	Roof repairs	1999	846	85	10	85		275	32
33	Carpet in front office	1999	8,881	1,776	5	1,776		5,625	33
34	TOTAL (lines 1 thru 33)		\$ 4,761,771	\$ 21,055		\$ 160,593	\$ 139,538	\$ 2,188,311	34

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

## 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	
1	Totals from Page 12B, Carried Forward		\$ 4,761,771	\$ 21,055		\$ 160,593	\$ 139,538	\$ 2,188,311	1
2	Yard signs	1999	2,825	282	10	282		871	2
3	New tees & valves	1999	11,685	1,168	10	1,168		3,603	3
4	Vinyl wall covering	1999	1,127	113	10	113		338	4
5	Shower room repair	1999	8,220	822	10	822		2,466	5
6	Connection fees for sewer project	1998	7,438	744	10	744		2,665	6
7	Tree removal	1999	9,857	986	10	986		2,793	7
8	Condenser	1999	12,396	1,240	10	1,240		3,512	8
9	Leasehold improvement:	1999	2,598	519	5	519		1,472	9
10	Landscaping	1999	18,255	1,825	10	1,825		4,943	10
11	Drop rod assembly	1999	6,408	641	10	641		1,762	11
12	Fencing	1999	3,840	384	10	384		1,024	12
13	Trees	1999	9,905	990	10	990		2,559	13
14	Roof repairs	2000	2,300	230	10	230		537	14
15	Tile floor - resident wing	2000	34,740	3,474	10	3,474		8,106	15
16	Painting	2000	6,352	1,270	5	1,270		2,859	16
17	Window replacement	2000	2,009	201	10	201		452	17
18	Leasehold improvement:	1999	5,754	1,151	5	1,151		2,725	18
19	Cabinet modification	1999	4,520	646	7	646		1,614	19
20	Professional electrical service:	1999	17,310	1,161	15	1,161		3,482	20
21	New sign out front	1999	900	180	5	180		540	21
22	Masonry work for BJC	1999	23,465	1,564	15	1,564		4,693	22
23	Professional plumbing & heating service:	1999	31,000	2,067	15	2,067		6,200	23
24	Remodeling	1999	19,524	1,302	15	1,302		3,905	24
25	Parking lot stripes	2000	1,549	310	5	310		594	25
26	Painting basement ceiling	2000	664	133	5	133		199	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,006,512	\$ 44,458		\$ 183,996	\$ 139,538	\$ 2,252,225	34

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

Facility Name & ID Number Brother James Court

# 0020495

Report Period Beginning:

07/01/01

Ending:

6/30/02

**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	
1	Totals from Page 12C, Carried Forward		\$ 5,006,512	\$ 44,458		\$ 183,996	\$ 139,538	\$ 2,252,225	1
2	Draperies	2001	10,881	1,859	5	1,859		1,859	2
3	Ramp area decorating	2001	14,387	2,637	5	2,637		2,637	3
4	Painting & wallcovering	2001	8,058	1,343	5	1,343		1,343	4
5	Air curtain	2001	1,812	216	7	216		216	5
6	Recepticles - Bedrooms	2001	9,820	1,309	5	1,309		1,309	6
7	Shower room floor repair	2002	1,123	56	10	56		56	7
8	Door repairs	2002	6,197	218	10	218		218	8
9	Boiler repair	2002	3,960	396	5	396		396	9
10	Draperies	2002	4,200	350	5	350		350	10
11	Architect fees - remodel bathroom are	2002	9,863	1,096	3	1,096		1,096	11
12	Repave sidewalks	2002	810	20	10	20		20	12
13	Tuckpointing	2002	1,490	25	10	25		25	13
14	Repair floors	2002	2,688	45	10	45		45	14
15	Parking lot blacktop	2000	49,310		15	3,287	3,287	5,753	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	TOTAL (lines 1 thru 33)		\$ 5,131,111	\$ 54,028		\$ 196,853	\$ 142,825	\$ 2,267,548	34

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

Facility Name & ID Number: Brother James Cour # 0020495 Report Period Beginning: 07/01/01 Ending: 6/30/02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instruction

	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	\$ 801,601	\$ 105,212	\$ 105,212	\$		\$ 447,851	71
72	Current Year Purchases	48,820	4,978	4,978			4,978	72
73	Fully Depreciated Assets	714,410	10,002	10,002			714,410	73
74								74
75	TOTALS	\$ 1,564,831	\$ 120,192	\$ 120,192	\$		\$ 1,167,239	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 Resident	Trucks	Various	\$ 72,449	\$ 11,146	\$ 11,146	\$		\$ 47,515	76
77	Transportation	Vans (& wheelchair lift)	Various	34,424	2,709	2,709			25,393	77
78		Cars	Various	41,823	8,073	8,073			36,837	78
79										79
80	TOTALS			\$ 148,696	\$ 21,928	\$ 21,928	\$		\$ 109,745	80

E. Summary of Care-Related Asset

	1	2	
	Reference	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)	\$ 6,844,638 81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 196,148 82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 338,973 83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 142,825 84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,544,532 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 1

**XII. RENTAL COSTS**

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

1. Name of Party Holding Lease: Franciscan Brothers of the Holy Cross (related party)  
 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	TOTAL				\$			7

10. Effective dates of current rental agreement:  
 Beginning 1975  
 Ending 2011

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

	Fiscal Year Ending	Annual Rent
12.	<u>6/30/2003</u>	\$ <u>270,000</u>
13.	<u>6/30/2004</u>	\$ <u>270,000</u>
14.	<u>6/30/2005</u>	\$ <u>270,000</u>

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 N/A

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: \$ NONE Description: \_\_\_\_\_  
 (Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

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

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

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

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

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 checked="" type="checkbox"/> YES <input 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 checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE <u>40</u></p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE <u>85</u></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		90		90
3 Classroom Wages (a)				
4 Clinical Wages (b)				
5 In-House Trainer Wage (c)		720		720
6 Transportation				
7 Contractual Payment:				
8 Nurse Aide Competency Tests				
9 TOTALS	\$	\$ 810	\$	\$ 810
10 SUM OF line 9, col. 1 and 2 (e)	\$	810		

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)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefit;
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefit;
- (c) For in-house training programs only. Do not include fringe benefit;
- (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	1 Schedule V Line & Column Reference	2		3		4		5		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8	
			Units of Service	Cost	Outside Practitioner (other than consultant)		Total Cost (Col. 3 + 5 + 6)							
					Units	Cost								
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$			\$	1	
2	Licensed Speech and Language Development Therapist		hrs										2	
3	Licensed Recreational Therapist		hrs										3	
4	Licensed Physical Therapist		hrs										4	
5	Physician Care		visits										5	
6	Dental Care		visits										6	
7	Work Related Program		hrs										7	
8	Habilitation		hrs										8	
9	Pharmacy		# of prescrpts										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>			\$		\$	\$		\$		\$		14	

**NOTE:** This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed 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 & ID Number Brother James Court

# 0020495

Report Period Beginning: 07/01/01

Ending:

6/30/02

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/02

(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	\$ 925,355	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	769,080		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	20,593		6
7	Other Prepaid Expenses	9,096		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,724,124	\$	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments	1,607,026		12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	741,021		15
16	Equipment, at Historical Cost	1,713,527		16
17	Accumulated Depreciation (book methods)	(1,634,111)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 2,427,463	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 4,151,587	\$	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 13,610	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	38,683		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	Accrued vacation	65,111		36
37	Other (miscellaneous)	1,680		37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 119,084	\$	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>	\$ 119,084	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 4,032,503	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 4,151,587	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>3,639,586</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>3,639,586</b>	<b>6</b>
<b>A. Additions (deductions):</b>			
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>392,917</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owner:	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>392,917</b>	<b>17</b>
<b>B. Transfers (Itemize):</b>			
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>4,032,503</b>	<b>24</b> *

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

Facility Name &amp; ID Number Brother James Court

# 0020495

Report Period Beginning: 07/01/01

Ending:

6/30/02

**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 expenses.**

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 3,520,569	1
2	Discounts and Allowances for all Level	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 3,520,569	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
9	Payments for Educator		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursement:	12,305	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patient		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services:	6,284	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 18,589	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	614,249	24
25	Interest and Other Investment Income**	95,636	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 709,885	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>Fundraising</b>	50,978	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 50,978	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 4,300,021	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	919,999	31
32	Health Care	1,394,149	32
33	General Administrator	926,624	33
<b>B. Capital Expense</b>			
34	Ownership	466,148	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers		35
36	Provider Participation Fee	200,184	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 3,907,104	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	392,917	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 392,917	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 **Brother James Court**

# **0020495**

Report Period Beginning: **07/01/01**

Ending:

**6/30/02**

**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	1,829	2,080	\$ 49,223	\$ 23.66	1
2	Assistant Director of Nursing					2
3	Registered Nurses	1,807	1,855	38,185	20.58	3
4	Licensed Practical Nurses	9,304	11,644	193,253	16.60	4
5	Nurse Aides & Orderlies					5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Worker	3,120	3,120	65,520	21.00	11
12	Dietician					12
13	Food Service Supervisor	3,120	3,120	65,520	21.00	13
14	Head Cook					14
15	Cook Helpers/Assistants	25,415	28,551	229,762	8.05	15
16	Dishwashers					16
17	Maintenance Worker	7,437	8,028	110,736	13.79	17
18	Housekeepers	6,247	6,677	61,957	9.28	18
19	Laundry	4,053	4,511	52,165	11.56	19
20	Administrator	3,120	3,120	70,080	22.46	20
21	Assistant Administrator					21
22	Other Administrative			9,579		22
23	Office Manager					23
24	Clerical	8,584	9,091	134,909	14.84	24
25	Vocational Instructor					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	9,245	11,311	121,016	10.70	28
29	Resident Services Coordinator	3,120	3,120	65,520	21.00	29
30	Habilitation Aides (DD Homes)	74,315	80,078	814,311	10.17	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	160,716	176,306	\$ 2,081,736 *	\$ 11.81	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	Various	\$ 1,507	35
36	Medical Director	Various	2,400	36
37	Medical Records Consultant	Various	205	37
38	Nurse Consultant			38
39	Pharmacist Consultant	Various	1,200	39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant	Various	2,846	41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant	Various	3,230	43
44	Activity Consultant			44
45	Social Service Consultant	Various	11,100	45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)		\$ 22,488	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	Nurse Aides			52
53	TOTAL (lines 50 - 52)		\$	53

Facility Name & ID Number Brother James Court

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Brother David Sarnecki	Administrator		\$ 70,080	Workers' Compensation Insurance	\$ 22,689	IDPH License Fee	\$	
				Unemployment Compensation Insurance	12,413	Advertising: Employee Recruitment	2,685	
				FICA Taxes	130,160	Health Care Worker Background Check (Indicate # of checks performed)		
				Employee Health Insurance	167,297	Membership dues	958	
				Employee Meals		Subscriptions	644	
				Illinois Municipal Retirement Fund (IMRF)*				
				Pension Contribution	109,613			
				Life Insurance	2,968			
				Other Employee Benefits	8,372			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 70,080	TOTAL (agree to Schedule V, line 22, col.8)		\$ 4,287		
B. Administrative - Other							Less: Public Relations Expense ( )	
Description			Amount				Non-allowable advertising ( )	
Background checks			\$ 557				Yellow page advertising ( )	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 557				TOTAL (agree to Sch. V, line 20, col. 8)	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Sikich Gardner & Co, LLP	Acctg, Audit, Technology		\$ 17,038			\$	Out-of-State Travel	\$
First USA Bank	Administrative		1,601				NONE	
Bank One	Administrative		2,733				In-State Travel	
Illinois National Bank	Administrative		6,623				NONE	
Bunn Capital	Administrative		180				Seminar Expense	1,095
ICAN	Administrative		283				Entertainment Expense ( )	
BISYS	Administrative		766				(agree to Sch. V, line 24, col. 8)	
Payday Management	Administrative		468				TOTAL	\$ 1,095
Sheehan & Sheehan	Legal		725					
Stratton & Giganti	Legal		28,310					
Other	Administrative		329					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 59,056	TOTAL		\$		

\* Attach copy of IMRF notifications

\*\*See instructions.



Facility Name & ID Number Brother James Court# 0020495Report Period Beginning: 07/01/01Ending: 6/30/02**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 NO  
If YES, give association name and amount N/A
- (3) Did the nursing home make political contributions or payments to a political organization? NO If YES, have these costs been properly adjusted out of the cost report N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? YES  
What was the average life used for new equipment added during this period? 5-7 YEARS
- (6) Indicate the total amount of both disposable and non-disposable diaper expenses and the location of this expense on Sch. V. 2,223 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation
- (8) Are you presently operating under a sale and leaseback arrangement? NO  
If YES, give effective date of lease N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. 200,184  
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 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 if 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. \$ NONE Has any meal income been offset against related costs? NO Indicate the amount \$ N/A
- (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? YES If YES, please indicate the amount of income earned from such program during this reporting period. \$ 6,284
- c. What percent of all travel expense relates to transportation of nurses and patients? 100%
- d. Have vehicle usage logs been maintained? YES
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? NO**  
**Indicate the amount of income earned from providing such transportation during this reporting period \$ NONE**
- (17) Has an audit been performed by an independent certified public accounting firm? YES  
Firm Name: Sikich Gardner & Co, LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? YES If no, please explain N/A
- (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? YES  
Attach invoices and a summary of services for all architect and appraisal fees