



Facility Name & ID Number SCALABRINI LIFE CENTER

# 0018317 Report Period Beginning: 07/01/02 Ending: 06/30/03

**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	120	Skilled (SNF)	120	43,800	1
2		Skilled Pediatric (SNF/PED)			2
3	26	Intermediate (ICF)	26	9,490	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	146	TOTALS	146	53,290	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		3 Public Aid Recipient	4 Private Pay	Other		
8	SNF	23,329	5,511	3,074	31,914	8
9	SNF/PED					9
10	ICF	3,015	1,611		4,626	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	26,344	7,122	3,074	36,540	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 68.57%

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

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?  
YES  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 01/01/1976

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 12 and days of care provided 3,074

Medicare Intermediary ADMINISTAR FEDERAL

**IV. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 06/30/03 Fiscal Year: 06/30/03

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

Facility Name &amp; ID Number

SCALABRINI LIFE CENTER

# 0018317

Report Period Beginning:

07/01/02

Ending:

06/30/03

**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	315,803	44,057	6,573	366,433		366,433		366,433		1
2	Food Purchase		232,288		232,288		232,288		232,288		2
3	Housekeeping	107,963	11,293	127,874	247,130		247,130		247,130		3
4	Laundry	34,120	4,431		38,551		38,551		38,551		4
5	Heat and Other Utilities			180,233	180,233		180,233		180,233		5
6	Maintenance	74,090	6,789	68,572	149,451		149,451	5,010	154,461		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	531,976	298,858	383,252	1,214,086		1,214,086	5,010	1,219,096		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			12,000	12,000		12,000		12,000		9
10	Nursing and Medical Records	1,836,666	110,642	157,311	2,104,619		2,104,619	853	2,105,472		10
10a	Therapy	2,403	1,432	1,785	5,620		5,620		5,620		10a
11	Activities	76,529	2,611		79,140		79,140		79,140		11
12	Social Services	119,344	5,712	713	125,769		125,769	(780)	124,989		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	2,034,942	120,397	171,809	2,327,148		2,327,148	73	2,327,221		16
	<b>C. General Administration</b>										
17	Administrative	93,984		111,138	205,122		205,122	(518,634)	(313,512)		17
18	Directors Fees										18
19	Professional Services			72,368	72,368		72,368	93,017	165,385		19
20	Dues, Fees, Subscriptions & Promotions			215	215		215		215		20
21	Clerical & General Office Expenses	152,913		139,691	292,604		292,604	204,886	497,490		21
22	Employee Benefits & Payroll Taxes			840,624	840,624		840,624	55,882	896,506		22
23	Inservice Training & Education										23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			126,893	126,893		126,893		126,893		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	246,897		1,290,929	1,537,826		1,537,826	(164,849)	1,372,977		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,813,815	419,255	1,845,990	5,079,060		5,079,060	(159,766)	4,919,294		29

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

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

Facility Name &amp; ID Number

SCALABRINI LIFE CENTER

#0018317

Report Period Beginning:

07/01/02

Ending:

06/30/03

## 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			173,753	173,753		173,753	15,508	189,261			30
31	Amortization of Pre-Op. & Org.			59,532	59,532		59,532	(59,532)				31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			233,285	233,285		233,285	(44,024)	189,261			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	89,734	391,153		480,887		480,887		480,887			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			79,936	79,936		79,936		79,936			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>	89,734	391,153	79,936	560,823		560,823		560,823			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,903,549	810,408	2,159,211	5,873,168		5,873,168	(203,790)	5,669,378			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 SCALABRINI LIFE CENTER

# 0018317

Report Period Beginning: 07/01/02

Ending: 06/30/03

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				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				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>	\$		\$	30
			(62,446)		

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)	(532,497)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$	(532,497)	36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$	(594,943)	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

SCALABRINI LIFE CENTER

ID# 0018317

Report Period Beginning: 07/01/02

Ending: 06/30/03

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
1		\$	1
2	PERSONAL ITEMS	(780)	2
3	OTHER OPER. INCOME	0	3
4	COLLECTION EXPENSE	(2,134)	4
5	AMORTIZATION OF GOODWILL	(59,532)	5
6	DEFERRED MAINTENANCE	0	6
7	LEGAL FEES NON-ALLOWABLE PY	0	7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
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>	(62,446)	49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number SCALABRINI LIFE CENTER

# 0018317 Report Period Beginning:

07/01/02

Ending:

06/30/03

## 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	5,010	0	0	0	0	0	0	0	0	0	5,010	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	0	5,010	0	0	0	0	0	0	0	0	0	5,010	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	853	0	0	0	0	0	0	0	0	0	853	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	(780)	0	0	0	0	0	0	0	0	0	0	(780)	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>	(780)	853	0	0	0	0	0	0	0	0	0	73	16
	<b>C. General Administration</b>													
17	Administrative	0	(518,634)	0	0	0	0	0	0	0	0	0	(518,634)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	93,017	0	0	0	0	0	0	0	0	0	93,017	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(2,134)	207,020	0	0	0	0	0	0	0	0	0	204,886	21
22	Employee Benefits & Payroll Taxes	0	55,882	0	0	0	0	0	0	0	0	0	55,882	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>	(2,134)	(162,715)	0	0	0	0	0	0	0	0	0	(164,849)	28
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	(2,914)	(156,852)	0	0	0	0	0	0	0	0	0	(159,766)	29

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number SCALABRINI LIFE CENTER# 0018317 Report Period Beginning:07/01/02 Ending:06/30/03

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

	Capital Expense	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>D. Ownership</b>												
30	Depreciation	0	15,508	0	0	0	0	0	0	0	0	0	15,508 30
31	Amortization of Pre-Op. & Org.	(59,532)	0	0	0	0	0	0	0	0	0	0	(59,532) 31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0 32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0 33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0 34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0 35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 36
37	<b>TOTAL Ownership</b>	<b>(59,532)</b>	<b>15,508</b>	<b>0</b>	<b>(44,024) 37</b>								
	<b>Ancillary Expense</b>												
	<b>E. Special Cost Centers</b>												
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0 38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0 39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0 40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0 41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0 42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 43
44	<b>TOTAL Special Cost Centers</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 44</b>
	<b>GRAND TOTAL COST</b>												
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(62,446)</b>	<b>(141,344)</b>	<b>0</b>	<b>(203,790) 45</b>								

Facility Name & ID Number SCALABRINI LIFE CENTER

# 0018317

Report Period Beginning:

07/01/02

Ending:

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**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
		SEE ATTACHED				

**B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.**  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	17	MANAGEMENT FEES	\$ 518,634	RESURRECTION HEALTH CARE	100.00%	\$ (518,634)
2	V	21	SALARIES		RESURRECTION HEALTH CARE	100.00%	193,020
3	V	22	EMPLOYEE BENEFITS		RESURRECTION HEALTH CARE	100.00%	55,882
4	V	19	DATA PROCESSING		RESURRECTION HEALTH CARE	100.00%	14,489
5	V	19	PRUCHASING		RESURRECTION HEALTH CARE	100.00%	78,528
6	V	06	OPERATION OF PLANT		RESURRECTION HEALTH CARE	100.00%	5,010
7	V	10	NURSING ADMINISTRATION		RESURRECTION HEALTH CARE	100.00%	853
8	V	21	MISC. A&G		RESURRECTION HEALTH CARE	100.00%	14,000
9	V	30	CAPITAL RELATED COSTS		RESURRECTION HEALTH CARE	100.00%	15,508
10	V	39	LTC PHARMACY	391,153	RESURRECTION HEALTH CARE	100.00%	391,153
11	V						
12	V						
13	V						
14	Total		\$ 909,787			\$ 768,443	\$ * (141,344)

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

Facility Name & ID Number SCALABRINI LIFE CENTER # 0018317 Report Period Beginning: 07/01/02 Ending: 06/30/03

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference
						Hours	Percent	Description	Amount	
1	N/A								\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

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

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

Facility Name & ID Number SCALABRINI LIFE CENTER # 0018317 Report Period Beginning: 07/01/02 Ending: 06/30/03

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 RESURRECTION HEALTH CARE  
 Street Address 7435 W. TALCOTT  
 City / State / Zip Code CHICAGO  
 Phone Number ( 773 )792-9903  
 Fax Number ( 773 )594-8567

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	21 SALARIES	DIRECT COST	1	1	\$ 193,020	\$ 193,020	1	\$ 193,020	1
2	22 EMPLOYEE NENEFITS	DIRECT COST	1	1	55,882		1	55,882	2
3	19 DATA PROCESSING	DIRECT COST	1	1	14,489		1	14,489	3
4	19 PURCHSING	DIRECT COST	1	1	78,528		1	78,528	4
5	6 OPERATION OF OPLANT	DIRECT COST	1	1	5,010		1	5,010	5
6	10 NURSING ADMINISTRATION	DIRECT COST	1	1	853		1	853	6
7	21 MISC. A & G	DIRECT COST	1	1	14,000		1	14,000	7
8	30 CAPITAL RELATD COSTS	DIRECT COST	1	1	15,508		1	15,508	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				\$ 377,290	\$ 193,020		\$ 377,290	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	N/A										2								
3											3								
4											4								
5											5								
	<b>Working Capital</b>																		
6											6								
7	N/A										7								
8											8								
9	<b>TOTAL Facility Related</b>					\$	\$		\$		9								
	<b>B. Non-Facility Related*</b>																		
10											10								
11											11								
12	N/A										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 **SCALABRINI LIFE CENTER**# **0018317** Report Period Beginning: **07/01/02** Ending: **06/30/03****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 2002 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 2003 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 6.			\$	7														
Real Estate Tax History:																			
Real Estate Tax Bill for Calendar Year:		1998	8	<table border="1"> <tr> <td colspan="2"><b>FOR OHF USE ONLY</b></td> </tr> <tr> <td>13</td> <td>FROM R. E. TAX STATEMENT FOR 2002 \$</td> <td>13</td> </tr> <tr> <td>14</td> <td>PLUS APPEAL COST FROM LINE 5 \$</td> <td>14</td> </tr> <tr> <td>15</td> <td>LESS REFUND FROM LINE 6 \$</td> <td>15</td> </tr> <tr> <td>16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$</td> <td>16</td> </tr> </table>		<b>FOR OHF USE ONLY</b>		13	FROM R. E. TAX STATEMENT FOR 2002 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
<b>FOR OHF USE ONLY</b>																			
13	FROM R. E. TAX STATEMENT FOR 2002 \$	13																	
14	PLUS APPEAL COST FROM LINE 5 \$	14																	
15	LESS REFUND FROM LINE 6 \$	15																	
16	AMOUNT TO USE FOR RATE CALCULATION \$	16																	
	1999	9																	
	2000	10																	
	2001	11																	
	2002	12																	

**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:** 2002 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 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 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 2003 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.

**2002 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME SCALABRINI LIFE CENTER COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0018317

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 2002 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 2002.

(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 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 66,250 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories FOUR

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 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).

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: \_\_\_\_\_ 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	<u>FACILITY</u>	<u>148,750</u>	<u>1974</u>	<u>\$ 221,420</u>	<u>1</u>
2					<u>2</u>
3	<u>TOTALS</u>	<u>148,750</u>		<u>\$ 221,420</u>	<u>3</u>

Facility Name & ID Number SCALABRINI LIFE CENTER

# 0018317

Report Period Beginning:

07/01/02

Ending:

06/30/03

**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
Bed(s)*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Accumulated Depreciation
4	146	1976	1976	\$ 2,338,089	\$ 163,051	VARIOUS	\$ 163,051	\$ 3,384,533
5			2003	50,827	4,358	35	4,358	4,358
6								
7								
8								
<b>Improvement Type**</b>								
9	VARIOUS IMPROVEMENTS		1976	126,333				
10	VARIOUS IMPROVEMENTS		1983	116,680				
11	VARIOUS IMPROVEMENTS		1984	44,238				
12	VARIOUS IMPROVEMENTS		1985	66,220				
13	VARIOUS IMPROVEMENTS		1986	100,387				
14	VARIOUS IMPROVEMENTS		1987	69,243				
15	VARIOUS IMPROVEMENTS		1988	41,177				
16	VARIOUS IMPROVEMENTS		1989	35,358				
17	VARIOUS IMPROVEMENTS		1990	14,953				
18	VARIOUS IMPROVEMENTS		1991	32,337				
19	VARIOUS IMPROVEMENTS		1993	96,635				
20	VARIOUS IMPROVEMENTS		1994	136,996				
21	VARIOUS IMPROVEMENTS		1995	99,164				
22	VARIOUS IMPROVEMENTS		1996	115,325				
23	VARIOUS IMPROVEMENTS		1997	9,815				
24	VARIOUS IMPROVEMENTS		1998	105,277				
25	VARIOUS IMPROVEMENTS		1999	14,550				
26	VARIOUS IMPROVEMENTS		1999	1,500				
27	VARIOUS IMPROVEMENTS		1999	117,135				
28								
29								
30								
31	TOTAL LEASEHOLD IMPROVEMENT DEPRECIATION							
32								
33	ALLOCATION FROM RESURRECTION HEALTH CARE							
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

Facility Name &amp; ID Number SCALABRINI LIFE CENTER

# 0018317

Report Period Beginning:

07/01/02

Ending:

06/30/03

## 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	LANDSCAPE IMPROVEMENT	2000	\$ 8,877	\$		\$	\$	\$		37
38	FLOORING	2000	43,466							38
39	EMPLOYEE ENTRANCE DOOR & CARMERAS	2000	6,320							39
40	BLDG IMPRV. DINING, THERAPY & SHOWER ROOMS	2000	24,855							40
41	BLDG IMPROV. IDPH PLAN REVIEW FEE	2000	2,486							41
42	FIXED EQUIPEMNT IMPROVEMENT	2000	7,770							42
43	FIEC QUEIPMENT IMPROVEMENT	2000	1,860							43
44	LANDSCAPE IMPROVEMENT	2001	29,594							44
45	LANDSCAPE IMPROVEMENT	2001	475							45
46	BUILDING RENOVATION	2002	931							46
47	POWER CONSRUCTION	2001	950							47
48	LANDSCAPE IMPROVEMENT	2002	1,235							48
49	LANDSCAPE IMPROVEMENT	2002	2,255							49
50	DOWSPOUT REPAIR-PLUMBING	2002	2,760							50
51	TOPOGRAPHIC MANNING	2001	4,846							51
52	BLDG IMPROVEMENT	2002	754							52
53	BLDG IMPROVEMENT	2001	1,119							53
54	BLDG IMPROVEMENT	2001	2,066							54
55	BLDG IMPROVEMENT	2001	1,399							55
56	BLDG IMPROVEMENT	2001	583							56
57	POWER CONSRUCTION	2002	104,479							57
58	POWER CONSRUCTION	2002	27,105							58
59	POWER CONSRUCTION	2001	71,857							59
60	POWER CONSRUCTION	2001	16,610							60
61	POWER CONSRUCTION	2001	33,905							61
62	WINDOW TREATMENT	2001	5,782							62
63	REPAIR GENERATOR	2001	2,080							63
64	ARCHITECTURAL SERVICES	2001	2,230							64
65	SERVICE SWITCH	2002	8,353							65
66	LANDSCAPE IMPROVEMENT	2002	3,000							66
67	RELATED PARTY ALLOCATIONS									67
68										68
69										69
70	TOTAL (lines 4 thru 69)		\$ 4,152,241	\$ 167,409		\$ 167,409	\$	\$ 3,388,891		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		\$ 4,152,241	\$ 167,409		\$ 167,409	\$	\$ 3,388,891	1
2	SPRINKLER SYSTEM	2001	14,584						2
3	WATER PUMP	2001	2,514						3
4	CEILING & LINGT FIXTURES	2001	5,525						4
5	PHONE SYSTEM	2001	5,677						5
6	DATA CABLES	2002	1,155						6
7	ELECTRICAL REPAIRS	2001	2,790						7
8	ISOLATION VALVES	2002	2,740						8
9	HOT WATER TANK	2001	4,740						9
10	PHONE SYSTEM	2002	9,412						10
11	BLINDS	2001	1,706						11
12	PHONE SYSTEM	2001	15,686						12
13	SWITCH PROJECT - PHONE SYSTEM	2002	37,647						13
14	STORM PUMP	2003	2,245						14
15	HEATING SYSTEM	2003	2,395						15
16	HEATED BASE	2003	7,826						16
17	INSTALL COOLER	2003	36,340						17
18	GENERATOR REPAIRS	2003	2,021						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)		\$ 4,307,244	\$ 167,409		\$ 167,409	\$	\$ 3,388,891	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 12H, Carried Forward		\$ 4,307,244	\$ 167,409		\$ 167,409	\$	\$ 3,388,891	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									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,307,244	\$ 167,409		\$ 167,409	\$	\$ 3,388,891	34

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

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	\$ 1,383,542	\$ 64,112	\$ 64,112	\$	10	\$ 1,199,326	71
72	Current Year Purchases	8,408	1,765	1,765		10	1,765	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,391,950	\$ 65,877	\$ 65,877	\$		\$ 1,201,091	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				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 5,920,614	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 233,286	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 233,286	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,589,982	85

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

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

G. Construction-in-Progress

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

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

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

**XII. RENTAL COSTS**

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

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

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ <u>N/A</u>			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.	<u>/2004</u>	\$ _____
13.	<u>/2005</u>	\$ _____
14.	<u>/2006</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 \_\_\_\_\_.

9. Option to Buy:  YES  NO Terms: N/A \*

**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: \$ \_\_\_\_\_ 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		<u>N/A</u>			18
19					19
20					20
21	<b>TOTAL</b>		\$ _____	\$ _____	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.

**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><b>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</b></p> <p><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><b>2. CLASSROOM PORTION:</b></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><b>3. CLINICAL PORTION:</b></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	<b>TOTALS</b>	\$	\$	\$	\$
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	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8	
			Staff			Outside Practitioner (other than consultant)						
			Units of Service	Cost		Units	Cost					
1	Licensed Occupational Therapist	39-01	1048	hrs	\$ 29,805					1,048	\$ 29,805	1
2	Licensed Speech and Language Development Therapist	39-01	233	hrs	7,831					233	7,831	2
3	Licensed Recreational Therapist			hrs								3
4	Licensed Physical Therapist	39-01	1872	hrs	52,098					1,872	52,098	4
5	Physician Care			visits								5
6	Dental Care			visits								6
7	Work Related Program			hrs								7
8	Habilitation			hrs								8
9	Pharmacy	39-02		# of prescripts				391,153			391,153	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	TOTAL				\$ 89,734		\$	\$ 391,153		3,153	\$ 480,887	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 SCALABRINI LIFE CENTER

# 0018317

Report Period Beginning: 07/01/02

Ending:

06/30/03

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/03

(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	\$ 809,883	\$	1
2 Cash-Patient Deposits			2
3 Accounts & Short-Term Notes Receivable-Patients (less allowance )	851,756		3
4 Supply Inventory (priced at )			4
5 Short-Term Investments			5
6 Prepaid Insurance	3,426		6
7 Other Prepaid Expenses	3,311		7
8 Accounts Receivable (owners or related parties)			8
9 Other(specify): <u>Intercompany</u>	60,006		9
10 <b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,728,382	\$	10
<b>B. Long-Term Assets</b>			
11 Long-Term Notes Receivable			11
12 Long-Term Investments			12
13 Land	221,420		13
14 Buildings, at Historical Cost	2,577,131		14
15 Leasehold Improvements, at Historical Cost	1,785,455		15
16 Equipment, at Historical Cost	1,336,608		16
17 Accumulated Depreciation (book methods)	(4,589,982)		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): <u>Goodwill</u>	1,399,282		23
24 <b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 2,729,914	\$	24
25 <b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 4,458,296	\$	25

	1	2	
	Operating	After Consolidation*	
<b>C. Current Liabilities</b>			
26 Accounts Payable	\$ 25,636	\$	26
27 Officer's Accounts Payable			27
28 Accounts Payable-Patient Deposits			28
29 Short-Term Notes Payable			29
30 Accrued Salaries Payable			30
31 Accrued Taxes Payable (excluding real estate taxes)			31
32 Accrued Real Estate Taxes(Sch.IX-B)			32
33 Accrued Interest Payable			33
34 Deferred Compensation			34
35 Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>			
36 <u>Resident Trust Fund</u>	53,046		36
37 <u>Intercompany Liabilities</u>	3,947,363		37
38 <b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 4,026,045	\$	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>	\$ 4,026,045	\$	46
47 <b>TOTAL EQUITY(page 18, line 24)</b>	\$ 432,251	\$	47
48 <b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 4,458,296	\$	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ 1,310,298	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ 1,310,298	6
	<b>A. Additions (deductions):</b>		
7	NET Income (Loss) (from page 19, line 43)	(878,047)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ (878,047)	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>	\$ 432,251	24 *

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

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# 0018317

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**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	\$ 6,318,688	1
2	Discounts and Allowances for all Levels	(2,576,278)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 3,742,410	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	383,541	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 383,541	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		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	513,451	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	315,209	21
22	Laundry	40,510	22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 869,170	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$	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>	\$ 4,995,121	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,351,859	31
32	Health Care	2,903,549	32
33	General Administration	785,218	33
<b>B. Capital Expense</b>			
34	Ownership	233,286	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	519,320	35
36	Provider Participation Fee	79,936	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 5,873,168	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(878,047)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (878,047)	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.

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**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	1,912	2,000	\$ 73,502	\$ 36.75	1
2	Assistant Director of Nursing	3,121	3,300	106,452	32.26	2
3	Registered Nurses	22,081	24,739	643,442	26.01	3
4	Licensed Practical Nurses	13,038	14,531	320,492	22.06	4
5	Nurse Aides & Orderlies	52,786	53,058	692,778	13.06	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	3,016	3,201	89,734	28.03	7
8	Rehab/Therapy Aides	176	176	2,403	13.65	8
9	Activity Director	26	26	524	20.15	9
10	Activity Assistants	6,011	6,760	76,005	11.24	10
11	Social Service Workers	4,607	5,427	119,344	21.99	11
12	Dietician	1,811	1,995	42,069	21.09	12
13	Food Service Supervisor	2,212	2,391	41,363	17.30	13
14	Head Cook	2,008	2,152	31,168	14.48	14
15	Cook Helpers/Assistants	3,995	4,381	53,526	12.22	15
16	Dishwashers	15,049	16,491	147,677	8.96	16
17	Maintenance Workers	3,953	4,395	74,090	16.86	17
18	Housekeepers	11,657	13,049	107,963	8.27	18
19	Laundry	3,082	3,720	34,120	9.17	19
20	Administrator	2,272	2,504	93,984	37.53	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	13,676	16,783	152,913	9.11	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	166,489	181,079	\$ 2,903,549 *	\$ 16.03	34

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

\*\* See instructions.

**B. CONSULTANT SERVICES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	\$		35	
36	Medical Director	MONTHLY	12,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	\$	12,000		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

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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	
Nair Radha	Director	0	\$ 9,998	Workers' Compensation Insurance	\$ 22,181	IDPH License Fee	\$	
Lacy Mary Ellen	Administrator	0	83,986	Unemployment Compensation Insurance	6,762	Advertising: Employee Recruitment		
				FICA Taxes	205,372	Health Care Worker Background Check (Indicate # of checks performed _____)		
				Employee Health Insurance	452,338	LSN Fees	215	
				Employee Meals				
				Illinois Municipal Retirement Fund (IMRF)*				
				Group Life Insurance	6,460			
				Group Dental Insurance	13,564			
				Employee Retirement Plan	107,627			
				Employee Group Disability	14,491			
				Other Employee Benefits	4,052	Less: Public Relations Expense	( )	
				Resurrection Health Care Allocation	7,776	Non-allowable advertising	( )	
						Yellow page advertising	( )	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 93,984	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
B. Administrative - Other				\$ 840,623		\$ 215		
Description			Amount	E. Schedule of Non-Cash Compensation Paid to Owners or Employees				
RESURRECTION HC - MANAGEMENT FEES			\$ 518,634	Description	Line #	Amount	G. Schedule of Travel and Seminar**	
				N/A			Description	
							Amount	
							Out-of-State Travel	
							\$	
							In-State Travel	
							Seminar Expense	
							Entertainment Expense	
							( )	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 518,634	TOTAL		\$	(agree to Sch. V, line 24, col. 8)	
C. Professional Services						TOTAL		
Vendor/Payee	Type		Amount					
			\$					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$					

\* Attach copy of IMRF notifications

\*\*See instructions.

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

1	2	3	4	5										
				6										
1	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year									
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	
1	Painting & Decorating	6/1998	\$ 14,592		\$ 4,864	\$ 4,864	\$	\$	\$	\$	\$	\$	\$	
2	Air Conditioner Rep.	6/1998	2,910		970	485								
3	Painting & Decorating	6/1999	3,633		1,211	1,211	908							
4	Painting & Decorating	6/2000	3,754		626	1,251	1,251	626						
5														
6														
7														
8														
9														
10														
11														
12														
13														
14														
15														
16														
17														
18														
19														
20	TOTALS		\$ 24,889		\$ 7,671	\$ 7,811	\$ 2,159	\$ 626	\$	\$	\$	\$	\$	

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## XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? YES  
If YES, give association name and amount. Life Services Network \$ 185
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? YES  
What was the average life used for new equipment added during this period? 10
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 13,418 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. \$ 79,936  
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. \$ \_\_\_\_\_ Has any meal income been offset against related costs? N/A Indicate the amount. \$ \_\_\_\_\_
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? NO  
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 100%
- d. Have vehicle usage logs been maintained? YES
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? NO**  
**Indicate the amount of income earned from providing such transportation during this reporting period.** \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? YES  
Firm Name: KPMG PEAT MARWICK 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. \_\_\_\_\_
- (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? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.