

Facility Name & ID Number ST BENEDICT NURSING & REHAB# 0044784 Report Period Beginning: 7/1/2002 Ending: 6/30/003

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>99</u>	Skilled (SNF)	<u>99</u>	<u>36,135</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>99</u>	TOTALS	<u>99</u>	<u>36,135</u>	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	<u>6,340</u>	<u>15,282</u>	<u>1,692</u>	<u>23,314</u>	8
9	SNF/PED					9
10	ICF	<u>2,278</u>	<u>9,568</u>		<u>11,846</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>8,618</u>	<u>24,850</u>	<u>1,692</u>	<u>35,160</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.30%D. How many bed-hold days during this year were paid by Public Aid?
58 (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)
NoneF. Does the facility maintain a daily midnight census? YesG. 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 3/01/00J. Was the facility purchased or leased after January 1, 1978?
YES Date 03/01/00 NO K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 7 and days of care provided 1,692Medicare 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 Fiscal Year: 06/30

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

STATE OF ILLINOIS

Facility Name & ID Number **ST BENEDICT NURSING & REHAB** # **0044784** Report Period Beginning: **7/1/2002** Ending: **6/30/003**

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
A. General Services											
1	Dietary	367,583	27,493	7,589	402,665		402,665	(87,646)	315,019		1
2	Food Purchase		280,670		280,670		280,670	(66,159)	214,511		2
3	Housekeeping	131,144	6,955		138,099		138,099	(30,059)	108,040		3
4	Laundry	166,456	45,147		211,603		211,603	(46,058)	165,545		4
5	Heat and Other Utilities			232,194	232,194		232,194	(50,540)	181,654		5
6	Maintenance	127,071	10,391	98,448	235,910		235,910	(80,560)	155,350		6
7	Other (specify):*										7
8	TOTAL General Services	792,254	370,656	338,231	1,501,141		1,501,141	(361,022)	1,140,119		8
B. Health Care and Programs											
9	Medical Director			13,343	13,343		13,343		13,343		9
10	Nursing and Medical Records	1,635,691	32,550	54,956	1,723,197		1,723,197	5,602	1,728,799		10
10a	Therapy	83,262	1,210		84,472		84,472		84,472		10a
11	Activities	122,709	19,692	3,162	145,563		145,563	(217)	145,346		11
12	Social Services	124,570	2,350	12,804	139,724		139,724		139,724		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,966,232	55,802	84,265	2,106,299		2,106,299	5,385	2,111,684		16
C. General Administration											
17	Administrative	86,464		492,648	579,112		579,112	(492,648)	86,464		17
18	Directors Fees										18
19	Professional Services							103,046	103,046		19
20	Dues, Fees, Subscriptions & Promotions			4,724	4,724		4,724		4,724		20
21	Clerical & General Office Expenses	168,321	10,376	153,632	332,329		332,329	96,631	428,960		21
22	Employee Benefits & Payroll Taxes			960,098	960,098		960,098	61,463	1,021,561		22
23	Inservice Training & Education										23
24	Travel and Seminar			883	883		883		883		24
25	Other Admin. Staff Transportation			1,102	1,102		1,102	(1,102)			25
26	Insurance-Prop.Liab.Malpractice			131,944	131,944		131,944		131,944		26
27	Other (specify):*										27
28	TOTAL General Administration	254,785	10,376	1,745,031	2,010,192		2,010,192	(232,610)	1,777,582		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,013,271	436,834	2,167,527	5,617,632		5,617,632	(588,247)	5,029,385		29

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

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

Facility Name & ID Number

ST BENEDICT NURSING & REHAB

#0044784

Report Period Beginning:

7/1/2002

Ending:

6/30/003

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	
	D. Ownership											
30	Depreciation			351,588	351,588		351,588	(39,189)	312,399			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			5,345	5,345		5,345		5,345			35
36	Other (specify):*											36
37	TOTAL Ownership			356,933	356,933		356,933	(39,189)	317,744			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	45,349	460,991	16,513	522,853		522,853		522,853			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			54,203	54,203		54,203		54,203			42
43	Other (specify):*	91,566		63,711	155,277		155,277	(153,999)	1,278			43
44	TOTAL Special Cost Centers	136,915	460,991	134,427	732,333		732,333	(153,999)	578,334			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,150,186	897,825	2,658,887	6,706,898		6,706,898	(781,435)	5,925,463			45

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

Facility Name & ID Number **ST BENEDICT NURSING & REHAB**

0044784

Report Period Beginning: **7/1/2002**

Ending: **6/30/003**

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	(2,565)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				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	(115,400)	21		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	(600,181)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (718,146)		\$	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)	(63,289)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (63,289)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (781,435)		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	TOTAL (C): (sum of lines 38-46)			\$		47

ST BENEDICT NURSING & REHAB

ID# 0044784

Report Period Beginning: 7/1/2002

Ending: 6/30/003

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Activities Income	\$ (217)	11	1
2	Billboard Rental	(1,200)	21	2
3	House Rental	(31,075)	6	3
4	Assisted Living	(153,999)	43	4
5	Collections	(1)	21	5
6	Marketing	(15,250)	21	6
7	INDEPENDENT LIVING EXPENSES			7
8	Dietary	(87,646)	1	8
9	Food	(61,092)	2	9
10	Housekeeping	(30,059)	3	10
11	Laundry	(46,058)	4	11
12	Utilities	(50,540)	5	12
13	Maintenance	(51,349)	6	13
14	Transportation Income	(1,102)	25	14
15	Vending Income	(2,502)	2	15
16	Capitalized Repairs & Maintenance	(5,104)	6	16
17	Non-Care Depreciation	(61,697)	30	17
18	Telephone Commission	(1,290)	21	18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(600,181)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number ST BENEDICT NURSING & REHAB

0044784

Report Period Beginning:

7/1/2002

Ending:

6/30/003

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)	
	A. General Services													
1	Dietary	(87,646)	0	0	0	0	0	0	0	0	0	0	(87,646)	1
2	Food Purchase	(66,159)	0	0	0	0	0	0	0	0	0	0	(66,159)	2
3	Housekeeping	(30,059)	0	0	0	0	0	0	0	0	0	0	(30,059)	3
4	Laundry	(46,058)	0	0	0	0	0	0	0	0	0	0	(46,058)	4
5	Heat and Other Utilities	(50,540)	0	0	0	0	0	0	0	0	0	0	(50,540)	5
6	Maintenance	(87,528)	6,968	0	0	0	0	0	0	0	0	0	(80,560)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(367,990)	6,968	0	(361,022)	8								
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	5,602	0	0	0	0	0	0	0	0	0	5,602	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(217)	0	0	0	0	0	0	0	0	0	0	(217)	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	TOTAL Health Care and Programs	(217)	5,602	0	5,385	16								
	C. General Administration													
17	Administrative	0	(492,648)	0	0	0	0	0	0	0	0	0	(492,648)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	103,046	0	0	0	0	0	0	0	0	0	103,046	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(133,141)	229,772	0	0	0	0	0	0	0	0	0	96,631	21
22	Employee Benefits & Payroll Taxes	0	61,463	0	0	0	0	0	0	0	0	0	61,463	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	(1,102)	0	0	0	0	0	0	0	0	0	0	(1,102)	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(134,243)	(98,367)	0	(232,610)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(502,450)	(85,797)	0	(588,247)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number ST BENEDICT NURSING & REHAB# 0044784

Report Period Beginning:

7/1/2002

Ending:

6/30/003

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)
	D. Ownership												
30	Depreciation	(61,697)	22,508	0	0	0	0	0	0	0	0	0	(39,189) 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 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	TOTAL Ownership	(61,697)	22,508	0	(39,189) 37								
	Ancillary Expense												
	E. Special Cost Centers												
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0 38
39	Ancillary Service Centers	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):*	(153,999)	0	0	0	0	0	0	0	0	0	0	(153,999) 43
44	TOTAL Special Cost Centers	(153,999)	0	0	0	0	0	0	0	0	0	0	(153,999) 44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(718,146)	(63,289)	0	(781,435) 45								

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
Resurrection Health Care		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 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)
1	V	21 Salary	\$	Resurrection Health Care		201,667	\$ 201,667 1
2	V	22 Employee Benefit		Resurrection Health Care		61,463	61,463 2
3	V	19 Data Processing		Resurrection Health Care		85,872	85,872 3
4	V	19 Purchasing		Resurrection Health Care		17,174	17,174 4
5	V	6 Operation of Plant		Resurrection Health Care		6,968	6,968 5
6	V	10 Nursing Administration		Resurrection Health Care		5,602	5,602 6
7	V	21 Miscellaneous A&G		Resurrection Health Care		28,105	28,105 7
8	V	30 Capital		Resurrection Health Care		22,508	22,508 8
9	V						9
10	V	17 Intercompany Services	492,648	Resurrection Health Care			(492,648) 10
11	V	39 Intercompany Pharmacy	398,729	Resurrection Health Care		398,729	11
12	V						12
13	V						13
14	Total		\$ 891,377			\$ 828,088	\$ * (63,289) 14

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

Facility Name & ID Number ST BENEDICT NURSING & REHAB # 0044784 Report Period Beginning: 7/1/2002 Ending: 6/30/003

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number ST BENEDICT NURSING & REHAB # 0044784 Report Period Beginning: 7/1/2002 Ending: 6/30/03

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 HC/Medical Center
 Street Address 7435 W. Talcott
 City / State / Zip Code Chicago, IL 60631
 Phone Number (773)774-8000
 Fax Number (773)594-7488

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 Salary				\$	\$		201,667	1
2	22 Employee Benefit							61,463	2
3	19 Data Processing							85,872	3
4	19 Purchasing							17,174	4
5	6 Operation of Plant							6,968	5
6	10 Nursing Administration							5,602	6
7	21 Miscellaneous A& G							28,105	7
8	30 Capital							22,508	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				\$	\$		429,359	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	Name of Lender	2		3	4	5	6		7	8	9	10						
			Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
			YES	NO											Original	Balance			
		A. Directly Facility Related																	
		Long-Term																	
1								\$	\$			\$	1						
2													2						
3													3						
4													4						
5													5						
		Working Capital																	
6													6						
7													7						
8													8						
9		TOTAL Facility Related						\$	\$			\$	9						
		B. Non-Facility Related*																	
10													10						
11													11						
12													12						
13													13						
14		TOTAL Non-Facility Related						\$	\$			\$	14						
15		TOTALS (line 9+line14)						\$	\$			\$	15						

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)**B. Real Estate Taxes**

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.																
1.	Real Estate Tax accrual used on 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. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5														
6.	Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6														
7.	Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	7														
Real Estate Tax History:																		
Real Estate Tax Bill for Calendar Year:		1998 _____ 8	<table border="1"> <tr> <td colspan="2">FOR OHF USE ONLY</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>		FOR OHF USE ONLY		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
FOR OHF USE ONLY																		
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 ST BENEDICT NURSING & REHAB COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0044784

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. _____	_____	\$ _____	\$ _____
	TOTALS	\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

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

If YES, attach an explanation & 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: 56,961 B. General Construction Type: Exterior Brick Frame Metal Number of Stories 2

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).

Assisted Living

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility/Land Study		2000	\$ 2,589,820	1
2	Purchases-see page 11 supplement			567,370	2
3	TOTALS			\$ 3,157,190	3

Facility Name & ID Number ST BENEDICT NURSING & REHAB# 0044784

Report Period Beginning:

7/1/2002

Ending:

6/30/003**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*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4		2000	1991	\$ 4,247,413	\$	35	\$	\$	\$
5									
6									
7									
8									
Improvement Type**									
9	Carpet 1st & 2nd floor halls,dining & patient rooms		2000	48,482		10			
10	Facility Sign		2000	7,845		10			
11	Grease Basin		2000	17,015		7			
12	Alternator Switches		2001	631		10			
13	Lawn Sprinkler Systems		2001	756		10			
14	High Velocity Water Jet		2000	322		10			
15	Catch Basin		2000	1,029		10			
16	Sewer Ejector Pump Repairs		2001	3,194		10			
17	Sewer Ejector Pump Repairs		2001	2,556		10			
18	Replacement of Hot Water System		2001	11,840		20			
19	Replacement of Hot Water System		2001	11,840		20			
20	Asbestos Removal from Boiler		2001	10,156		10			
21	HVAC		2001	1,523		10			
22	Carpet		2001	804		7			
23	HVAC		2001	1,395		10			
24	Valve		7/23/2001	798		10			
25	Hot Water System		10/31/2001	11,840		20			
26	Hot Water Tank		7/31/2001	3,013		20			
27	Refrigeration Lines		9/25/2001	1,094		10			
28	Electrical		9/30/2001	3,529		10			
29	Boiler Pipe		10/12/2001	1,748		10			
30	Expansion Study		10/31/2001	15,503		20			
31	Voice Cables		12/14/2001	747		10			
32	Professional Services		1/22/2002	9,129		15			
33	Wreck Building		5/31/2002	8,804		15			
34	Antenna		12/31/2002	3,917		10			
35	Circulating Pump		2/28/2003	2,111		10			
36	Receivers		3/31/2003	18,090		5			

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

See Page 12A, Line 70 for total

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

STATE OF ILLINOIS

Facility Name & ID Number ST BENEDICT NURSING & REHAB

0044784

Report Period Beginning:

7/1/2002

Ending:

Page 12A

6/30/003

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	Condensing Unit	4/30/2003	\$ 4,167	\$	15	\$	\$	\$		37
38	Conduits	6/30/2003	2,676		20					38
39	Fire Alarm	2001	423		7					39
40	Fire Alarm	2001	1,811		7					40
41	Door	1/20/2002	603		10					41
42	Pump	1/22/2002	989		10					42
43	Power Lines	1/30/2002	603		10					43
44	Pump Catch Basis	2/1/2002	563		10					44
45	Swing Door	2/25/2002	708		10					45
46	Fire Protection	3/10/2002	1,811		7					46
47	Air conditioning	4/24/2002	812		10					47
48	Condenser Motor	5/23/2002	451		10					48
49	Air conditioning	5/31/2002	717		10					49
50	Air conditioning	5/31/2002	714		10					50
51	Refrigerator Ball Valves	6/10/2002	1,356		10					51
52	Freezer	6/12/2002	1,104		10					52
53	Valve	6/24/2002	1,817		10					53
54	Condensor Motor	7/11/2002	564		10					54
55	Compressor	7/15/2002	1,162		5					55
56	Convactor Motor	8/14/2002	515		10					56
57	Fire Protection	10/1/2002	1,811		7					57
58	Pump System	10/24/2002	1,805		10					58
59	Fire Protection	1/10/2003	1,811		7					59
60	Fire Protection	1/24/2003	1,811		7					60
61	Circulating Pump	1/28/2003	1,401		10					61
62	Fire Protection	4/8/2003	1,811		7					62
63	Air Station	4/9/2003	1,897		10					63
64										64
65										65
66										66
67										67
68	Depreciation			161,685		161,685		434,496		68
69										69
70	TOTAL (lines 4 thru 69)		\$ 4,483,037	\$ 161,685		\$ 161,685	\$	\$ 434,496		70

**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	\$ 644,832	\$ 127,941	\$ 127,941	\$	10	\$ 464,391	71
72	Current Year Purchases	5,299	265	265		10	265	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 650,131	\$ 128,206	\$ 128,206	\$		\$ 464,656	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	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)	\$ 8,290,358	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 289,891	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 289,891	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)	\$ 899,152	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	Depreciable Non-Care Assets	\$ 1,095,075	\$ 61,697	\$ 221,611	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 1,095,075	\$ 61,697	\$ 221,611	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: _____
 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 _____
 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: _____ *

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					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.

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?</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>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
--	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		1	2	3	4
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the 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 Total Cost (Col. 3 + 5 + 6)	
			Staff		Outside Practitioner (other than consultant)		Units	Cost						
			Units of Service	Cost	Units	Cost								
1	Licensed Occupational Therapist	39-01	hrs	\$ 1,080		\$ 7,079						\$ 8,159	1	
2	Licensed Speech and Language Development Therapist	39-01	hrs	715		9,435						10,150	2	
3	Licensed Recreational Therapist		hrs										3	
4	Licensed Physical Therapist	39-01	hrs	43,598								43,598	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						398,729			398,729	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs										10	
11	Academic Education		hrs										11	
12	Exceptional Care Program												12	
13	Other (specify): See Supplemental								57,594			57,594	13	
14	TOTAL			\$ 45,393		\$ 16,514		\$ 456,323				\$ 518,230	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.

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

	1	2	
	Operating	After Consolidation*	
A. Current Assets			
1 Cash on Hand and in Banks	\$ 119,007	\$	1
2 Cash-Patient Deposits	13,914		2
3 Accounts & Short-Term Notes Receivable-Patients (less allowance)	(42,605)		3
4 Supply Inventory (priced at)			4
5 Short-Term Investments			5
6 Prepaid Insurance			6
7 Other Prepaid Expenses	4,325		7
8 Accounts Receivable (owners or related parties)	1,419,218		8
9 Other(specify):			9
TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,513,859	\$	10
B. Long-Term Assets			
11 Long-Term Notes Receivable			11
12 Long-Term Investments			12
13 Land	3,158,120		13
14 Buildings, at Historical Cost	5,412,712		14
15 Leasehold Improvements, at Historical Cost	24,565		15
16 Equipment, at Historical Cost	845,939		16
17 Accumulated Depreciation (book methods)	(1,120,763)		17
18 Deferred Charges			18
19 Organization & Pre-Operating Costs			19
20 Accumulated Amortization - Organization & Pre-Operating Costs	61,140		20
21 Restricted Funds			21
22 Other Long-Term Assets (specify):			22
23 Other(specify):			23
TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 8,381,713	\$	24
TOTAL ASSETS (sum of lines 10 and 24)	\$ 9,895,572	\$	25

	1	2	
	Operating	After Consolidation*	
C. Current Liabilities			
26 Accounts Payable	\$ 47,463	\$	26
27 Officer's Accounts Payable			27
28 Accounts Payable-Patient Deposits	24,858		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
Other Current Liabilities(specify):			
36			36
37			37
TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 72,321	\$	38
D. Long-Term Liabilities			
39 Long-Term Notes Payable			39
40 Mortgage Payable			40
41 Bonds Payable			41
42 Deferred Compensation			42
Other Long-Term Liabilities(specify):			
43			43
44			44
TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 72,321	\$	46
47 TOTAL EQUITY (page 18, line 24)	\$ 9,823,251	\$	47
TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 9,895,572	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 9,576,397	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 9,576,397	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	246,854	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 246,854	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 9,823,251	24 *

* This must agree with page 17, line 47.

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	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 6,784,438	1
2	Discounts and Allowances for all Levels	(1,020,568)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,763,870	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	262,299	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 262,299	8
C. Other Operating Revenue			
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	5,572	13
14	Non-Patient Meals	2,565	14
15	Telephone, Television and Radio	1,290	15
16	Rental of Facility Space	185,074	16
17	Sale of Drugs	361,684	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	4,606	19
20	Radiology and X-Ray		20
21	Other Medical Services	314,678	21
22	Laundry	21,746	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 897,215	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	30,368	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 30,368	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,953,752	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,501,141	31
32	Health Care	2,106,299	32
33	General Administration	2,010,192	33
B. Capital Expense			
34	Ownership	356,933	34
C. Ancillary Expense			
35	Special Cost Centers	678,130	35
36	Provider Participation Fee	54,203	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,706,898	40
41	Income before Income Taxes (line 30 minus line 40)**	246,854	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 246,854	43

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

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

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

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

Facility Name & ID Number **ST BENEDICT NURSING & REHAB**

0044784

Report Period Beginning: **7/1/2002**

Ending:

6/30/03

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	1,732	1,875	\$ 52,775	\$ 28.15	1
2	Assistant Director of Nursing					2
3	Registered Nurses	17,747	19,249	522,343	27.14	3
4	Licensed Practical Nurses	5,313	5,764	117,957	20.46	4
5	Nurse Aides & Orderlies	69,465	76,418	889,554	11.64	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	1,619	1,854	44,312	23.90	7
8	Rehab/Therapy Aides	6,700	7,445	84,298	11.32	8
9	Activity Director	2,317	2,547	51,713	20.30	9
10	Activity Assistants	7,712	8,666	70,996	8.19	10
11	Social Service Workers	7,370	8,184	165,882	20.27	11
12	Dietician					12
13	Food Service Supervisor	1,773	2,008	47,067	23.44	13
14	Head Cook					14
15	Cook Helpers/Assistants	31,606	34,232	320,516	9.36	15
16	Dishwashers					16
17	Maintenance Workers	6,455	7,263	127,072	17.50	17
18	Housekeepers	15,953	17,886	151,047	8.44	18
19	Laundry	15,619	17,521	146,553	8.36	19
20	Administrator	1,863	2,176	86,464	39.74	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,876	9,780	142,131	14.53	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,031	2,191	37,939	17.32	31
32	Other Health Care(specify)					32
33	Other(specify)	8,784	9,398	91,567	9.74	33
34	TOTAL (lines 1 - 33)	212,935	234,457	\$ 3,150,186 *	\$ 13.44	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	13,343	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	Monthly	2,052	11-03	44
45	Social Service Consultant	57	1,980	12-03	45
46	Other(specify)				46
47	Spiritual Services		10,260	12-03	47
48					48
49	TOTAL (lines 35 - 48)	57	\$ 27,635		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	473	\$ 23,023	10-03	50
51	Licensed Practical Nurses	750	25,589	10-03	51
52	Nurse Aides	171	3,441	10-03	52
53	TOTAL (lines 50 - 52)	1,394	\$ 52,053		53

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
Peter Goschy	Administrator		\$ 86,464	Workers' Compensation Insurance	\$ 24,444	IDPH License Fee	\$
				Unemployment Compensation Insurance	7,950	Advertising: Employee Recruitment	
				FICA Taxes	229,483	Health Care Worker Background Check	
				Employee Health Insurance	529,499	(Indicate # of checks performed _____)	
				Employee Meals		Dues & Subscriptions	4,724
				Illinois Municipal Retirement Fund (IMRF)*			
				Group Life/Dental	23,430		
				Retirement Plan	115,412		
				Group Disability	17,330		
				Employee Assistance/Other Benefits	3,216		
				Pre-employment screening	4,914	Less: Public Relations Expense	()
				Corp Allocation of Tuition Reimbursement	4,420	Non-allowable advertising	()
						Yellow page advertising	()
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 86,464	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)	
B. Administrative - Other				\$ 960,098		\$ 4,724	
Description			Amount				
Resurrection Intercompany Services			\$ 492,648				
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 492,648				
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
Vendor/Payee	Type		Amount	Description	Line #	Amount	G. Schedule of Travel and Seminar**
			\$			\$	Description
							Amount
							Out-of-State Travel
							\$
							In-State Travel
							Seminar Expense
							883
							Entertainment Expense
							()
							(agree to Sch. V, line 24, col. 8)
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$	TOTAL		\$	TOTAL
							883

* Attach copy of IMRF notifications

**See instructions.

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 \$4,724
- (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? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 11,049 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. _____
- (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. \$ 54,203
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? Yes For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 2,565
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 100%
d. Have vehicle usage logs been maintained? N/A
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. \$ _____
- (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.

Facility Name & ID Number ST BENEDICT NURSING & REHAB #0044784 Report Period Beginning 7/1/2002 Ending: 6/30/003

V. COST CENTER EXPENSES

Supplement to Page 4

Detail of Line 43-Other

Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total
	Salary/Wage	Supplies	Other	Total				
Assisted Living	91,566		63,711	155,277		155,277	(153,999)	1,278
TOTAL , Other	91,566	0	63,711	155,277	0	155,277	(153,999)	1,278

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility/Land Study		2000	\$ 2,589,820	1
2a	6948 W. Touhy		2001	242,308	2a
2b	6910 W. Touhy		2002	325,062	2b
3	TOTALS			\$ 3,157,190	3

XIV. SPECIAL SERVICES

Special Services -Supplies(Column 6 Other)

13a	Chargeable Supplies & Services-Other	44,812
13b	Chargeable Supplies & Services-Rebates	(1,525)
13c	DME Medical & Surgical Supplies	3,481
13d	DME Oxygen & Gas	5,812
13e	Nursing Lab Services	4,473
13f	Nursing X-Ray Services	541
		<u>57,594</u>

XVII. INCOME STATEMENT

Detail of line 28

Incontinence Clinic Inpatient Revenue	20,991
Other Revenue Miscellaneous	6,976
Other Revenue Vending Commission	984
Other Revenue Activities	217
Other Revenue Billboard Rental	1,200
	<u>30,368</u>

XVIII. A. STAFFING AND SALARY COSTS

Supplemental Schedule of Staffing & Salary Costs

		1	2	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
33a	Assisted Living	8,784	9,398	91,567	9.74	33a
33	Total Other	8,784	9,398	\$ 91,567	\$ 9.74	33