

		FOR BHF USE					

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2006
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2006)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p>I. IDPH Facility ID Number: <u>0044776</u></p> <p>Facility Name: <u>St Andrew Life Center</u></p> <p>Address: <u>7000 North Newark</u> <u>Niles</u> <u>60714</u> Number City Zip Code</p> <p>County: <u>Cook</u></p> <p>Telephone Number: <u>(847) 647-8332</u> Fax # <u>(847) 647-7073</u></p> <p>HFS ID Number: <u>237061646007</u></p> <p>Date of Initial License for Current Owners: <u>03/01/2000</u></p> <p>Type of Ownership:</p> <table style="width:100%"> <tr> <td><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input checked="" type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code <u>501(c)(3)</u></td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Christine A. Hanover</u> Telephone Number: <u>(312) 634-4581</u> Please send copies of desk review and audit adjustments to address on this page.</p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code <u>501(c)(3)</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>07/01/2005</u> to <u>06/30/2006</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table style="width:100%"> <tr> <td style="width:20%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td></td> <td colspan="2">(Type or Print Name) _____</td> </tr> <tr> <td></td> <td colspan="2">(Title) _____</td> </tr> <tr> <td>Paid Preparer</td> <td>(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u></td> <td>(Date) _____</td> </tr> <tr> <td></td> <td colspan="2">(Print Name and Title) _____</td> </tr> <tr> <td></td> <td colspan="2">(Firm Name & Address) <u>Altschuler, Melvoin and Glasser LLP</u> <u>One South Wacker Drive, Suite 800, Chicago, IL 60606</u></td> </tr> <tr> <td></td> <td>(Telephone) <u>(312) 384-6000</u></td> <td>Fax # (312) 634-5518</td> </tr> </table> <p align="center">MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001</p> <p align="right">Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____	(Date) _____		(Type or Print Name) _____			(Title) _____		Paid Preparer	(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u>	(Date) _____		(Print Name and Title) _____			(Firm Name & Address) <u>Altschuler, Melvoin and Glasser LLP</u> <u>One South Wacker Drive, Suite 800, Chicago, IL 60606</u>			(Telephone) <u>(312) 384-6000</u>	Fax # (312) 634-5518
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SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Andrew Life Center

0044776 Report Period Beginning: 07/01/2005 Ending: 06/30/2006

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	<u>55</u>	Intermediate (ICF)	<u>55</u>	<u>20,075</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>55</u>	TOTALS	<u>55</u>	<u>20,075</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF	<u>7,999</u>	<u>10,249</u>		<u>18,248</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>7,999</u>	<u>10,249</u>		<u>18,248</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.90%

D. How many bed-hold days during this year were paid by the Department? 3 (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 Non-allowable costs have been eliminated in Schedule V, Column 7.

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 03/01/2000

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified _____ and days of care provided N/A

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 06/30/2006 Fiscal Year: 06/30/2006

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Andrew Life Center # 0044776 Report Period Beginning: 07/01/2005 Ending: 06/30/2006

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	463,395	43,194	1,275	507,864		507,864	(316,836)	191,028		1
2	Food Purchase		328,779		328,779		328,779	(210,161)	118,618		2
3	Housekeeping	221,602	5,785		227,387		227,387	(141,858)	85,529		3
4	Laundry	64,881	20,323		85,204		85,204	(53,155)	32,049		4
5	Heat and Other Utilities			324,230	324,230		324,230	(202,274)	121,956		5
6	Maintenance	178,645	22,248	112,999	313,892		313,892	(195,825)	118,067		6
7	Other (specify):*										7
8	TOTAL General Services	928,523	420,329	438,504	1,787,356		1,787,356	(1,120,109)	667,247		8
	B. Health Care and Programs										
9	Medical Director			12,000	12,000		12,000		12,000		9
10	Nursing and Medical Records	788,296	46,436	550	835,282		835,282	1,542	836,824		10
10a	Therapy	11,619			11,619		11,619		11,619		10a
11	Activities	159,125	4,985	1,871	165,981		165,981		165,981		11
12	Social Services	45,680	74	800	46,554		46,554		46,554		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Assisted Living	267,896	662	2,827	271,385		271,385	(271,385)			15
16	TOTAL Health Care and Programs	1,272,616	52,157	18,048	1,342,821		1,342,821	(269,843)	1,072,978		16
	C. General Administration										
17	Administrative	83,062		406,844	489,906		489,906	(406,844)	83,062		17
18	Directors Fees										18
19	Professional Services										19
20	Dues, Fees, Subscriptions & Promotions			6,443	6,443		6,443	377	6,820		20
21	Clerical & General Office Expenses	215,347	18,544	44,345	278,236		278,236	108,779	387,015		21
22	Employee Benefits & Payroll Taxes			936,439	936,439		936,439	(235,744)	700,695		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,471	2,471		2,471	(408)	2,063		24
25	Other Admin. Staff Transportation			293	293		293		293		25
26	Insurance-Prop.Liab.Malpractice			133,997	133,997		133,997	15,030	149,027		26
27	Other (specify):*										27
28	TOTAL General Administration	298,409	18,544	1,530,832	1,847,785		1,847,785	(518,810)	1,328,975		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,499,548	491,030	1,987,384	4,977,962		4,977,962	(1,908,762)	3,069,200		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

**See schedule of adjustments attached at end of cost report.

Facility Name & ID Number St Andrew Life Center

#0044776

Report Period Beginning: 07/01/2005 Ending: 06/30/2006

06/30/2006

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			301,121	301,121		301,121	(219,498)	81,623			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			3,207	3,207		3,207		3,207			35
36	Other (specify):*											36
37	TOTAL Ownership			304,328	304,328		304,328	(219,498)	84,830			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		182,527		182,527		182,527		182,527			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			30,113	30,113		30,113		30,113			42
43	Other (specify):* Nonallowable Cost			17,137	17,137		17,137	(17,137)				43
44	TOTAL Special Cost Centers		182,527	47,250	229,777		229,777	(17,137)	212,640			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,499,548	673,557	2,338,962	5,512,067		5,512,067	(2,145,397)	3,366,670			45

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

**See schedule of adjustments attached at end of cost report.

SEE ACCOUNTANTS' COMPILATION REPORT

See Accountants' Compilation Report

Facility Name & ID Number St Andrew Life Center

0044776

Report Period Beginning: 07/01/2005

Ending: 06/30/2006

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	(5,049)	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				24
25	Fund Raising, Advertising and Promotional	(17,137)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See PG5A	(1,890,595)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,912,781)		\$	30

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)	(232,616)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (232,616)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (2,145,397)		37

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

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

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

BHF USE ONLY							
48		49		50		51	52

SEE ACCOUNTANTS' COMPILATION REPORT

St Andrew Life Center

ID# 0044776

Report Period Beginning: 07/01/2005

Ending: 06/30/2006

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Pension Expense Adjustment	\$ 35,032	22	1
2	Offset miscellaneous revenue	(1,310)	21	2
3	Malpractice Expense Adjustment	15,030	26	3
4				4
5	Disallow Assisted living wages	(267,896)	15	5
6	Disallow Assisted living supplies	(662)	15	6
7	Disallow Assisted living other expenses	(2,827)	15	7
8				8
9				9
10				10
11	Disallow housekeeping allocated to Assisted Living	(141,858)	3	11
12	Disallow laundry exp allocated to Assisted living	(53,155)	4	12
13	Disallow administrative outside services allocated to Assi:	(2,174)	21	13
14	Disallow benefits allocated to assisted living	(317,384)	22	14
15	Disallow food expense allocated to assisted living	(205,112)	2	15
16	Disallow utilities allocated to Assisted living	(202,274)	5	16
17	Disallow maintenance expense allocated to Assisted living	(195,825)	6	17
18	Disallow dietary wages allocated to Assisted living	(316,836)	1	18
19	Disallow depreciation expense allocated to Assisted living	(233,344)	30	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	(1,890,595)		49

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Summary A

Facility Name & ID Number St Andrew Life Center

0044776

Report Period Beginning:

07/01/2005

Ending:

06/30/2006

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	(316,836)	0	0	0	0	0	0	0	0	0	0	(316,836)	1
2	Food Purchase	(210,161)	0	0	0	0	0	0	0	0	0	0	(210,161)	2
3	Housekeeping	(141,858)	0	0	0	0	0	0	0	0	0	0	(141,858)	3
4	Laundry	(53,155)	0	0	0	0	0	0	0	0	0	0	(53,155)	4
5	Heat and Other Utilities	(202,274)	0	0	0	0	0	0	0	0	0	0	(202,274)	5
6	Maintenance	(195,825)	0	0	0	0	0	0	0	0	0	0	(195,825)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(1,120,109)	0	0	0	0	0	0	0	0	0	0	(1,120,109)	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	1,542	0	0	0	0	0	0	0	0	0	1,542	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	(271,385)	0	0	0	0	0	0	0	0	0	0	(271,385)	15
16	TOTAL Health Care and Programs	(271,385)	1,542	0	(269,843)	16								
	C. General Administration													
17	Administrative	0	(406,844)	0	0	0	0	0	0	0	0	0	(406,844)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(3,484)	112,232	0	0	0	0	0	0	0	0	0	108,748	21
22	Employee Benefits & Payroll Taxes	(282,352)	46,608	0	0	0	0	0	0	0	0	0	(235,744)	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	15,030	0	0	0	0	0	0	0	0	0	0	15,030	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(270,806)	(248,004)	0	(518,810)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(1,662,300)	(246,462)	0	(1,908,762)	29								

STATE OF ILLINOIS

Facility Name & ID Number St Andrew Life Center

0044776

Report Period Beginning:

07/01/2005 Ending:

Summary B

06/30/2006

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(233,344)	13,846	0	0	0	0	0	0	0	0	0	(219,498)	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	(233,344)	13,846	0	(219,498)	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):*	(17,137)	0	0	0	0	0	0	0	0	0	0	(17,137)	43
44	TOTAL Special Cost Centers	(17,137)	0	0	0	0	0	0	0	0	0	0	(17,137)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(1,912,781)	(232,616)	0	(2,145,397)	45								

Facility Name & ID Number St Andrew Life Center

0044776

Report Period Beginning: 07/01/2005 Ending: 06/30/2006

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	100	See Attached		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	10 Nursing Supplies	\$	Resurrection Health Care	100.00%	\$ 1,542	\$ 1,542	1
2	V	21 Clerical & Data Processing		Resurrection Health Care	100.00%	50,311	50,311	2
3	V	21 Other Administrative & General		Resurrection Health Care	100.00%	61,921	61,921	3
4	V	22 Employee Benefits		Resurrection Health Care	100.00%	46,608	46,608	4
5	V	30 Depreciation		Resurrection Health Care	100.00%	13,846	13,846	5
6	V							6
7	V	17 Intercompany Accrual	406,844	Resurrection Health Care	100.00%		(406,844)	7
8	V	39 Intercompany Pharmacy	182,527	Resurrection Health Care	100.00%	182,527		8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 589,371			\$ 356,755	\$ * (232,616)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Andrew Life Center # 0044776 Report Period Beginning: 07/01/2005 Ending: 06/30/2006

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	See attached pg. 7A									2
3										3
4										4
5	Sister Elizabeth Trembczynski	Director	Board of Directors	0.00	107,120	1	2.00	N/A	N/A	N/A
6										6
7	Sister Elizabeth Trembczynski is administrator of Holy Family Health Center, a related entity.									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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Andrew Life Center

0044776 Report Period Beginning: 07/01/2005 Ending: 6/30/2006

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/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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	10	Nursing Supplies			\$	\$		\$ 1,542	1
2	21	Clerical & Data Processing						50,311	2
3	21	Other Administrative & General						61,921	3
4	22	Employee Benefits						46,608	4
5	30	Depreciation						13,846	5
6									6
7	39	Intercompany Pharmacy						182,527	7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 356,755	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1										1										
2	N/A									2										
3										3										
4										4										
5										5										
Working Capital																				
6										6										
7	N/A									7										
8										8										
9	TOTAL Facility Related				\$	\$		\$		9										
B. Non-Facility Related*																				
10										10										
11	N/A									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. \$ None Line # N/A

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number St Andrew Life Center# 0044776 Report Period Beginning: 07/01/2005 Ending: 06/30/2006

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2005 report.		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		
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.)			\$	N/A
3. Under or (over) accrual (line 2 minus line 1).			\$	
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	
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.)			\$	
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.)			\$	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:				
2001	_____	8		
2002	_____	9		
2003	_____	10		
2004	_____	11		
2005	<u>N/A</u>	12		
Facility is a not-for-profit entity and does not pay real estate tax.				
			FOR BHF USE ONLY	
13	FROM R. E. TAX STATEMENT FOR 2005	\$		13
14	PLUS APPEAL COST FROM LINE 5	\$		14
15	LESS REFUND FROM LINE 6	\$		15
16	AMOUNT TO USE FOR RATE CALCULATION	\$		16

NOTES:

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

SEE ACCOUNTANTS' COMPILATION REPORT

See Accountants' Compilation Report

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2005 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 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 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,

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME St Andrew Life Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0044776

CONTACT PERSON REGARDING THIS REPORT Thomas W. Groenwald

TELEPHONE (773) 594-7837 FAX #: (773) 594-5867

A. Summary of Real Estate Tax Cos

Enter the tax index number and real estate tax assessed for 2005 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200!

(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. _____	<u>N/A</u>	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ _____	\$ _____

B. Real Estate Tax Cost Allocation:

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct 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 hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. Tax Bills

Attach a copy of the original 2005 tax bills which were listed in Section A to this statement. Be sure to use the 20C tax bill which is normally paid during 2006

PLEASE NOTE: Payment information from the Internet or otherwise is not considered acceptable tax bill documentation. Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number St Andrew Life Center

0044776 Report Period Beginning:

07/01/2005 Ending:

06/30/2006

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 155,990 B. General Construction Type: Exterior Brick Frame Masonry Number of Stories 6

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, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Assisted Living & Independent 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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Resident use</u>	<u>436,304</u>	<u>2000</u>	<u>\$ 2,600,000</u>	1
2					2
3	TOTALS	<u>436,304</u>		<u>\$ 2,600,000</u>	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	55		2000	1951	\$ 936,802	\$ 24,021	39	\$ 24,021	\$	\$ 220,748	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various		2000		5,782		20				9
10											10
11	Vacuum return system (20320)			2001	5,588		20				11
12	Boiler bottom (21955)			2001	6,038		20				12
13	Cross-header shaft (550)			2001	151		20				13
14	T&M Rebuilt (840)			2001	231		20				14
15	Plumbing (536)			2001	147		20				15
16	Bathroom light diffuser (510)			2001	140		20				16
17	Draperies (4300)			2001	1,183		20				17
18	Vertical blinds (1638)			2001	450		20				18
19	Circuit breaker (1519)			2001	418		20				19
20	Limestone repair (32000)			2001	8,800		20				20
21	Roof (7800)			2001	2,145		20				21
22	Elevator (47332)			2001	13,016		20				22
23	Pumps with new HP monitor(15965) - Alloc RHC			2001	4,390		20				23
24	Water leak & insulate (1817) - Alloc RHC			2001	500		20				24
25	Water gaskets (1063)			2002	292		20				25
26	Astro-slide (606)			2002	166		20				26
27	Hot water pump (618)			2002	170		20				27
28	Weiling pump (1568)			2002	431		20				28
29	Landscaping (13550)			2002	3,726		20				29
30	Land study (4175)			2002	1,148		20				30
31	Code review (9772)			2002	2,687		20				31
32	Land study (6925)			2002	1,904		20				32
33	Electrical elevator (8494)			2002	2,336		20				33
34	Carpet (1438)			2002	395		20				34
35	Fire alarm (6771)			2002	1,862		20				35
36											36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Andrew Life Center

0044776

Report Period Beginning:

07/01/2005 Ending: 06/30/2006

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	Land study (7710)	2002	\$ 2,120	\$	20	\$	\$	\$	37
38	Electrical work (1465)	2002	403		20				38
39	Architect Fees (11392)	2002	3,133		20				39
40	Fire Alarm (25658)	2002	7,056		20				40
41	Code review (9895)	2002	2,721		20				41
42	Life line Resp. Syst-50% pm (33290) - Alloc RHC	2002	9,155		20				42
43	Refrig. Piping (5000) - Alloc RHC	2002	1,375		20				43
44									44
45	Leak at condenser of freezer (2105) - Alloc RHC	2002	579		20				45
46	Prof Serv - Land Study (1080)	2002	297		20				46
47	Power line for overload panel (5712)	2002	1,571		20				47
48	Refrig piping (4881)	2002	1,342		20				48
49	Asbestos abatement-boiler #1 (15500)	2002	4,263		20				49
50	Fire alarm control panel (2599)	2002	715		20				50
51	Asbestos abatement -Boiler # 1 repair (4675)	2002	1,286		20				51
52	Replace leaking tube - Boiler #3 (1659)	2002	456		20				52
53	Building renovation (4794)	2002	1,318		20				53
54	Building renovation (4590)	2002	1,262		20				54
55	Prof Serv - Toilet renovation (1740)	2002	479		20				55
56	Replace stay bolts - Boiler #1 (2975)	2002	818		20				56
57	Replace leaking tube - Tank #2 (16585)	2002	4,561		20				57
58	Building renovation (152,758)	2002	42,008		20				58
59	Water system (783) *	2002	215		20				59
60	Cable & hose protector (631) *	2002	174		20				60
61	Boiler repair (573) *	2002	158		20				61
62	Replace stay bolts - Boiler #1 (7000)	2003	1,925		20				62
63	Prof serv - Code review (73)	2003	20		20				63
64	Prof serv - toilet renovation (1305)	2003	359		20				64
65	Rebuild firebox (8955)	2003	2,463		20				65
66	Reinsulate two boilers (4675)	2003	1,286		20				66
67	Modify steam supply & piping (25310)	2003	6,960		20				67
68	Replace leaking tubes in boiler (12695)	2003	3,491		20				68
69	Replace stairs & rails (5200)	2003	1,430		20				69
70	TOTAL (lines 4 thru 69)		\$ 1,106,297	\$ 24,021		\$ 24,021	\$	\$ 220,748	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

See Accountants' Compilation Report

Facility Name & ID Number St Andrew Life Center

0044776

Report Period Beginning:

07/01/2005 Ending: 06/30/2006

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		\$ 1,106,297	\$ 24,021		\$ 24,021	\$	\$ 220,748	1
2	<u>Lifeline response systems (69,519)</u>	2003	19,118		20				2
3	<u>Install new floor & base (4071)</u>	2003	1,120		20				3
4	<u>Demolition (23,200) **</u>	2003	6,380		20				4
5	<u>Prof. serv - Code Review (50) **</u>	2003	14		20				5
6	<u>Furnish wood doors hardware (2288) **</u>	2003	629		20				6
7	<u>Elevator safety tests (4321) **</u>	2003	1,188		20				7
8	<u>Radio system (786) **</u>	2003	216		20				8
9	<u>Filters (826)</u>	2003	227		20				9
10									10
11	<u>Code review</u>	2003	205		20				11
12	<u>Land study</u>	2003	6,743		20				12
13	<u>Appraisal</u>	2004	9,000		20				13
14	<u>Rebuild fire box for boiler</u>	2004	7,250		20				14
15	<u>Data cable installation</u>	2004	2,148		20				15
16	<u>Convent demolition</u>	2004	242,028		20				16
17	<u>Asbestos removal</u>	2004	49,460		20				17
18									18
19	<u>Reseal, stripe parking lot</u>	2005	6,975		10				19
20	<u>Landscaping</u>	2005	10,200		10				20
21	<u>Boiler upgrade</u>	2005	77,205		10				21
22	<u>Roof work</u>	2005	126,868		15				22
23	<u>Utility station - cabinets, flooring, counter tops</u>	2005	29,402		10				23
24	<u>Replace tube bundles</u>	2005	32,450		15				24
25	<u>Furnace stack, hot & chilled water piping</u>	2005	62,392		15				25
26	<u>Stairwell doors</u>	2005	18,121		15				26
27	<u>Safety sensors - front entrance doors</u>	2005	2,468		10				27
28	<u>Emergency boiler repairs</u>	2005	2,965		10				28
29	<u>Wiring</u>	2005	14,300		20				29
30	<u>Flooring tile & installation</u>	2005	11,650		10				30
31	<u>Architectural & planning services from Loeb</u>	2005	250,200		15				31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,097,219	\$ 24,021		\$ 24,021	\$	\$ 220,748	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 2,097,219	\$ 24,021		\$ 24,021	\$	\$ 220,748	1
2	Landscape Architectural Services	2006	9,838		7				2
3	Freezer Floor, Material & Installation	2006	2,058		15				3
4	Two Condensate Receiver/Pumps in Boiler Room	2006	8,465		10				4
5	Honeywell controller for 6th floor	2006	2,485		10				5
6	Rockford 3" grease trap in kitchen	2006	2,628		15				6
7	Replace bad convectors with Fin tube radiation	2006	2,741		8				7
8	Boiler upgrade	2006	1,600		15				8
9	4 Detex alarms/lock & keypad	2006	1,295		10				9
10	Install 4 tamper switches for fire protection	2006	2,969		15				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	Management Company Allocation					13,846	13,846		31
32	Financial Statement Depreciation			12,046		12,046		187,553	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,131,298	\$ 36,067		\$ 49,913	\$ 13,846	\$ 408,301	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number St Andrew Life Center # 0044776 Report Period Beginning: 07/01/2005 Ending: 06/30/2006

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 407,135	\$ 29,050	\$ 29,050		10	\$ 157,106	71
72	Current Year Purchases	70,418	2,660	2,660		5-20	2,660	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 477,553	\$ 31,710	\$ 31,710			\$ 159,766	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	N/A			\$	\$	\$			\$	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)	\$ 5,208,851	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 67,777	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 81,623	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 13,846	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 568,067	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	Non-care bldg & improvements-01	\$ 2,666,530	\$	\$	86
87	Non-care bldg equipment-01	507,976			87
88	Non-care bldg & improvements-03	284,062			88
89	Non-care equipment-03	17,328	233,344	1,343,801	89
90					90
91	TOTALS	\$ 3,475,896	\$ 233,344	\$ 1,343,801	91

G. Construction-in-Progress

	Description	Cost	
92	N/A		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.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ <u>N/A</u>			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>/2007</u>	\$ _____
13.	<u>/2008</u>	\$ _____
14.	<u>/2009</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 N/A
by the length of the lease N/A . N/A

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: \$ \$3,207 Description: Copier - 2,414, Admin. Eqpt. - 793

(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			\$ <u>N/A</u>	\$	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.

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides. 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 CNA _____</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 CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
 - (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
- SEE ACCOUNTANTS' COMPILATION REPORT**

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

	Service	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A (1)	330 hrs	11,619				330	11,619	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 (2)	# of prescripts				182,527		182,527	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			\$ 11,619		\$	\$ 182,527	330	\$ 194,146	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 17

Facility Name & ID Number St Andrew Life Center# 0044776Report Period Beginning: 07/01/2005Ending: 06/30/2006

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/2006 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 1,137	\$ 1,137	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>169,597</u>)	144,315	144,315	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	6,113	6,113	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Security Deposit</u>	22,944	22,944	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 174,509	\$ 174,509	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	2,600,000	2,600,000	13
14	Buildings, at Historical Cost	4,660,392	2,038,842	14
15	Leasehold Improvements, at Historical Cost	92,456	92,456	15
16	Equipment, at Historical Cost	1,225,433	477,553	16
17	Accumulated Depreciation (book methods)	(1,911,868)	(568,067)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	48,120	48,120	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(46,516)	(46,516)	20
21	Restricted Funds			21
22	Other Long-Term Assets (spe <u>Assisted Living</u>)		2,132,095	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 6,668,017	\$ 6,774,483	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,842,526	\$ 6,948,992	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 146,504	\$ 146,504	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
Other Current Liabilities(specify):				
36	<u>Due to Related Parties</u>	1,008,739	1,008,739	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,155,243	\$ 1,155,243	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,155,243	\$ 1,155,243	46
47	TOTAL EQUITY (page 18, line 24)	\$ 5,687,283	\$ 5,793,749	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,842,526	\$ 6,948,992	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

See Accountants' Compilation Report

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 5,895,432	1
2	Restatements (describe):		2
3	Prior Period Adjustment	10,206	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 5,905,638	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(218,355)	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)	\$ (218,355)	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)	\$ 5,687,283	24 *

Operating Entity Only

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Andrew Life Center# 0044776Report Period Beginning: 07/01/2005Ending: 06/30/2006**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	\$ 5,516,973	1
2	Discounts and Allowances for all Levels	(617,073)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,899,900	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	34,921	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 34,921	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	260	12
13	Barber and Beauty Care	14,314	13
14	Non-Patient Meals	5,049	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	15,552	16
17	Sale of Drugs	215,516	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	104,466	21
22	Laundry	250	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 355,407	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	Miscellaneous Revenue	3,484	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 3,484	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,293,712	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,787,356	31
32	Health Care	1,342,821	32
33	General Administration	1,847,785	33
B. Capital Expense			
34	Ownership	304,328	34
C. Ancillary Expense			
35	Special Cost Centers	199,664	35
36	Provider Participation Fee	30,113	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,512,067	40
41	Income before Income Taxes (line 30 minus line 40)**	(218,355)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (218,355)	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. SEE ACCOUNTANTS' COMPILATION REPORT

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

St. Andrew Life Center
Provider # 0044776
7/1/2005 - 6/30/2006

Schedule 19A

XVII - Income Statement: Line 22 - Laundry

NOTE: Laundry revenue is generated from charges to private pay residents located in the facility, therefore it has not been offset against related expenses.

Facility Name & ID Number St Andrew Life Center

0044776

Report Period Beginning: 07/01/2005

Ending:

06/30/2006

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	1,943	2,119	\$ 70,563	\$ 33.30	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,661	5,151	151,250	29.36	3
4	Licensed Practical Nurses	7,091	7,811	192,187	24.60	4
5	CNAs & Orderlies	25,316	28,045	374,296	13.35	5
6	CNA Trainees					6
7	Licensed Therapist	290	330	11,619	35.21	7
8	Rehab/Therapy Aides					8
9	Activity Director	3,735	4,171	104,276	25.00	9
10	Activity Assistants	3,909	4,370	54,849	12.55	10
11	Social Service Workers	1,912	2,080	45,680	21.96	11
12	Dietician	295	295	9,626	32.63	12
13	Food Service Supervisor	1,872	2,080	61,338	29.49	13
14	Head Cook	7,084	7,853	102,556	13.06	14
15	Cook Helpers/Assistants	28,569	32,342	289,875	8.96	15
16	Dishwashers					16
17	Maintenance Workers	9,510	10,748	178,645	16.62	17
18	Housekeepers	17,198	19,621	221,602	11.29	18
19	Laundry	4,725	5,295	64,881	12.25	19
20	Administrator	1,416	1,600	83,062	51.91	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,718	12,516	215,347	17.21	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) <u>Assisted Living</u>	18,040	20,127	267,896	13.31	33
34	TOTAL (lines 1 - 33)	149,284	166,554	\$ 2,499,548 *	\$ 15.01	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	9(3)	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	16	800	12(3)	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	16	\$ 12,800		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		N/A		51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

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	
Nikki Curth	Administrator	0	\$ 83,062	Workers' Compensation Insurance	\$ 35,442	IDPH License Fee	\$ 415	
				Unemployment Compensation Insurance	6,514	Advertising: Employee Recruitment		
				FICA Taxes	176,340	Health Care Worker Background Check		
				Employee Health Insurance	514,488	(Indicate # of checks performed _____)		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Life Services Network of Illinois dues	4,965	
				Employee Life Insurance	5,325	Miscellaneous Dues & Subscriptions	1,440	
				Employee Disability Insurance	9,074			
				Employee Retirement	199,673			
				Employee Dental Insurance	15,468			
				Employee Morale & Other Benefits	9,147	Less: Public Relations Expense	()	
				Home Office Allocation	46,608	Non-allowable advertising	()	
				Less: Nonallowable non-care benefit	(317,384)	Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)						TOTAL (agree to Sch. V, line 20, col. 8)		
					\$ 83,062			
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description				Description	Line #	Amount	Description	Amount
Management Fees				N/A			Out-of-State Travel	\$
(Eliminated on Sch. V, Line 17, Col. 7)								
							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)							Seminar Expense	
							See Attached	2,063
							Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)				TOTAL			TOTAL	
							\$ 2,063	

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2003	6 FY2004	7 FY2005	8 FY2006	9 FY2007	10 FY2008	11 FY2009	12 FY2010	13 FY2011
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2								N/A					
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

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 - \$4,965
- (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? 12.5 yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 14,137 Line 10(2)
- (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. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 30,113
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, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A
- (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 - Assisted Living 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. \$ 5,049
- (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? None
d. Have vehicle usage logs been maintained? Adequate records have been maintained.
e. Are all vehicles stored at the nursing home during the night and all 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: KMPG LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Audit not yet completed.
- (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.

SEE ACCOUNTANTS' COMPILATION REPORT

St. Andrew Life Center
 Facility ID#: 0044776
 Period: 7/01/05 - 6/30/06
 J. Livingston

Schedule 23A

Schedule XX - General Information: Question 14

A portion of the facility is used for Assisted Living.

METHOD OF ALLOCATION	Cost Per GL	(A) Allocation %	Allocated to Asst.Living
Dietary	507,864	62.39%	316,836
Food	328,779	62.39%	205,112
Hskpg	227,387	62.39%	141,858
Laundry	85,204	62.39%	53,155
Utilities	324,230	62.39%	202,274
Maintenance	313,892	62.39%	195,825
Employee Benefits	936,439	(B)	317,384
Miscellaneous Revenue	(3,484)	62.39%	(2,174)
Depreciation	301,121	SALY	233,344
			1,663,614

(A)

Census:	Assisted Living	31,795
Census:	Total	50,965
	Allocation %	62.39%

(B)

Employee benefits	936,439		
Total wages	2,499,548		
% of total wages	37.46%		
<u>Wages from which to allocate EE Benefits</u>			
Dietary	463,395		
Housekeeping	221,602		
Laundry	64,881		
Maintenance	178,645		
total	928,523	62.39%	579,268
Assisted Living	267,896	100.00%	267,896
			847,164
			0.3746
			317,384