

Facility Name & ID Number Brother James Court

0020495 Report Period Beginning: 07/01/06 Ending: 06/30/07

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 1/16/07

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	96	Intermediate/DD	99	35,538	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	96	TOTALS	99	35,538	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		2 Medicaid Recipient	3 Private Pay	4 Other		
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	34,034	365	365	34,764	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	34,034	365	365	34,764	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.82%

D. How many bed-hold days during this year were paid by the Department? 1,756 (Do not include bed-hold days in Section B.)

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO

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

I. On what date did you start providing long term care at this location?
Date started 10/01/1975

J. Was the facility purchased or leased after January 1, 1978?
YES Date _____ NO

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

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

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

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

Facility Name & ID Number **Brother James Court** # **0020495** Report Period Beginning: **07/01/06** Ending: **06/30/07**

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 BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	216,837	18,466	3,887	239,190		239,190	239,190			1
2	Food Purchase		149,338		149,338		149,338	149,338			2
3	Housekeeping	52,035	20,269		72,304		72,304	72,304			3
4	Laundry	51,163	3,080		54,243		54,243	54,243			4
5	Heat and Other Utilities			163,200	163,200		163,200	163,200			5
6	Maintenance	56,636	189	54,623	111,448		111,448	111,448			6
7	Other (specify):*										7
8	TOTAL General Services	376,671	191,342	221,710	789,723		789,723	789,723			8
	B. Health Care and Programs										
9	Medical Director			3,400	3,400		3,400	3,400			9
10	Nursing and Medical Records	1,442,887	32,515	3,300	1,478,702		1,478,702	1,478,702			10
10a	Therapy	21,662	745	25,793	48,200		48,200	48,200			10a
11	Activities		6,240	363	6,603		6,603	6,603			11
12	Social Services	141,597		6,000	147,597		147,597	147,597			12
13	CNA Training										13
14	Program Transportation			13,375	13,375		13,375	13,375			14
15	Other (specify):* Education										15
16	TOTAL Health Care and Programs	1,606,146	39,500	52,231	1,697,877		1,697,877	1,697,877			16
	C. General Administration										
17	Administrative			70,691	70,691		70,691	70,691			17
18	Directors Fees										18
19	Professional Services			105,119	105,119		105,119	105,119			19
20	Dues, Fees, Subscriptions & Promotions			6,681	6,681		6,681	6,681			20
21	Clerical & General Office Expenses	204,110	14,922	102,058	321,090		321,090	(76,431)	244,659		21
22	Employee Benefits & Payroll Taxes			439,552	439,552		439,552	439,552			22
23	Inservice Training & Education										23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			54,514	54,514		54,514	54,514			26
27	Other (specify):*										27
28	TOTAL General Administration	204,110	14,922	778,615	997,647		997,647	(76,431)	921,216		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,186,927	245,764	1,052,556	3,485,247		3,485,247	(76,431)	3,408,816		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

Brother James Court

#0020495

Report Period Beginning:

07/01/06

Ending:

06/30/07

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			146,227	146,227		146,227	106,809	253,036			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			270,000	270,000		270,000	(270,000)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			416,227	416,227		416,227	(163,191)	253,036			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			218,804	218,804		218,804		218,804			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			218,804	218,804		218,804		218,804			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,186,927	245,764	1,687,587	4,120,278		4,120,278	(239,622)	3,880,656			45

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

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	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(1,613)	21,3		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	(74,818)	21,1		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				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (76,431)		\$	30

BHF 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)	(163,191)	34,30	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (163,191)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (239,622)		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

Brother James Court

ID# 0020495

Report Period Beginning: 07/01/06

Ending: 06/30/07

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
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	0	49

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Brother James Court

0020495

Report Period Beginning:

07/01/06

Ending:

06/30/07

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	0	106,809	0	0	0	0	0	0	0	0	0	106,809 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	(270,000)	0	0	0	0	0	0	0	0	0	(270,000) 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	0	(163,191)	0	0	0	0	0	0	0	0	0	(163,191) 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):*	0	0	0	0	0	0	0	0	0	0	0	0 43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0 44
	GRAND TOTAL COST												
45	(sum of lines 29, 37 & 44)	0	(163,191)	0	0	0	0	0	0	0	0	0	(163,191) 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
N/A	N/A	N/A	None	Franciscan Brothers of The Holy Cross	Springfield	Religious Order
				Springfield Development Center		Day Training Prog.
				Weber Care Corp		Community Living Facility

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
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	34 Facility Rent	\$ 270,000	Franciscan Brothers of the Holy Cross	100.00%	\$	(270,000)	1
2	V	30 Depreciation		Franciscan Brothers of the Holy Cross	100.00%	106,809	106,809	2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 270,000			\$ 106,809	\$ * (163,191)	14

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

Facility Name & ID Number Brother James Court # 0020495 Report Period Beginning: 07/01/06 Ending: 06/30/07

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	Bro. Gerald Voycheck	Staff Trainer		None	None	Various	30.00	Consultant	\$ 3,447	21,3	1
2											2
3	Bro. Anthony Joseph McCoy	Mission Effectiveness		None	None	20	50.00	Consultant	17,520	21,3	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 20,967		13

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

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

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

0020495 Report Period Beginning: **07/01/06**

Ending: **06/30/07**

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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

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

Facility Name & ID Number **Brother James Court** # **0020495** Report Period Beginning: **07/01/06** Ending: **06/30/07**

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1 Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	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

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>																											
1. Real Estate Tax accrual used on 2006 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 2007 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:	<table border="1"> <tr><td>2002</td><td>8</td></tr> <tr><td>2003</td><td>9</td></tr> <tr><td>2004</td><td>10</td></tr> <tr><td>2005</td><td>11</td></tr> <tr><td>2006</td><td>12</td></tr> </table>	2002	8	2003	9	2004	10	2005	11	2006	12	<table border="1"> <tr><td colspan="2">FOR BHF USE ONLY</td></tr> <tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2006 \$</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 BHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2006 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
2002	8																										
2003	9																										
2004	10																										
2005	11																										
2006	12																										
FOR BHF USE ONLY																											
13	FROM R. E. TAX STATEMENT FOR 2006 \$	13																									
14	PLUS APPEAL COST FROM LINE 5 \$	14																									
15	LESS REFUND FROM LINE 6 \$	15																									
16	AMOUNT TO USE FOR RATE CALCULATION \$	16																									

NOTES:

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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,

2006 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Brother James Court COUNTY Sangamon

FACILITY IDPH LICENSE NUMBER 0020495

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Costs

Enter the tax index number and real estate tax assessed for 2006 on the lines provided below. Enter only the portion of total 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 2006.

(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 Allocation:

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 original 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007

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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 47,210 B. General Construction Type: Exterior BRICK/STONE Frame STEEL Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	FACILITY			\$ NOT AVAILABI	1
2					2
3	TOTALS			\$ #VALUE!	3

Facility Name & ID Number Brother James Court

0020495

Report Period Beginning:

07/01/06

Ending:

06/30/07

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 BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4		1975	1975	\$ 1,003,250	\$	30	\$	\$	\$ 1,003,250	4
5		1996	1996	1,251,493		30	41,716	41,716	438,023	5
6		1997	1997	1,256,490		30	41,883	41,883	381,596	6
7										7
8										8
Improvement Type**										
9	NEW WING-HEATING AND AIR CONDITIONING		1997	18,883		30	629	629	6,032	9
10	REPAVE PARKING LOT		1986	42,236		10			42,236	10
11	PAINTING/DECORATING		1979	2,951		5			2,591	11
12	BJC-BLDG IMPROVEMENTS		1980	16,233		11			16,233	12
13	BJC-BLDG IMPROVEMENTS		1984	21,419		10			21,419	13
14	BJC-REMODELING		1987	69,555		10			69,555	14
15	BJC-WATER LINE		1987	14,120		20	706	706	13,061	15
16	INSULATION		1991	9,175		15	357	357	9,175	16
17	ELECTRICAL REPAIR		1991	613		10			613	17
18	BOILER TANK REMOVAL		1992	15,089		20	754	754	11,099	18
19	TANK ROVEAL		1992	8,500		10			8,500	19
20	DISHWASHING ROOM SEWER		1992	10,680		20	534	534	8,010	20
21	BJC-STEAM LINE		1985	14,479		10			14,479	21
22	BJC-BLDG IMPROVEMENTS		1975	19,600		24			19,600	22
23	BJC-DINING AREA REMODELING		1976	34,951		10			34,951	23
24	BJC-SIDEWALK/PATIO		1976	3,545		10			3,545	24
25	BJC-BIKE RINK		1978	2,500		50			2,500	25
26	BJC-AIR CONDITIONING SYSTEM		1979	22,876		10			22,876	26
27	BJC-SITE IMPROVEMENT		1979	1,440		26			1,440	27
28	ROOF		1979	12,166		10			12,166	28
29	ROOFING		1986	45,811		10			45,811	29
30	REMODELING		1988	46,656		10			46,656	30
31	WATER LINE		1989	3,166		20	158	158	2,849	31
32	SEWAGE TREATMENT PLANT		1990	6,411		20	321	321	5,342	32
33	TANK ROVEAL		1991	9,809		10			9,809	33
34	PARKING LOT		1992	10,452		10			10,452	34
35	PAINT RESTROOMS		1992	230		5			230	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

Facility Name & ID Number Brother James Court

0020495

Report Period Beginning:

07/01/06

Ending:

06/30/07

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	BOILER ROOM REMODELING	1993	\$ 15,106	\$	20	\$ 755	\$ 755	\$ 10,203		37
38	REPAVE PARKING LOT	1994	850		10			850		38
39	PUMP	1994	734		10			734		39
40	AIRCONDITIONER WORK	1994	943		10			943		40
41	BOILER ROOM PROJECT	1994	170,330		20	8,517	8,517	105,247		41
42	LAND IMPROVEMENT - TREES	1996	2,470		20	174	174	1,793		42
43	BJC-BLDG IMPROVEMENTS	1998	15,712		30	524	524	4,626		43
44	WATER LINE REPAIR	1999	3,102		10	310	310	2,249		44
45	LAND IMPROVEMENT - TREES	1999	25,849		20	1,292	1,292	9,478		45
46	GATE	1999	550		5			550		46
47	REMODELING	1999	5,773		10	577	577	4,089		47
48	FLOOR	2000	1,683		7	240	240	1,603		48
49	TOTAL LIFE CENTER	1998	122,261		30	4,075	4,075	34,980		49
50	PARKIGLOTBLACKTOP	2000	49,310		15	3,287	3,287	22,189		50
51	LEASEHOLD IMPROVEMENTS	1985	15,200		10			15,200		51
52	LEASEHOLD IMPROVEMENTS	1986	19,507		10			19,507		52
53	PAINTING	1987	9,922		3			9,922		53
54	STEEL DOOR	1987	6,020		10			6,020		54
55	WINDOW REPLACEMENT	1987	2,013		10			2,013		55
56	GENERATOR SWITCH	1988	3,335		10			3,335		56
57	REMODEL LOBBY	1989	156,996	5,233	30	5,233		92,017		57
58	BUS HUT	1989	4,715		15			4,715		58
59	WATER HEATER	1989	6,721		10			6,721		59
60	TRANSFER SWITCH	1989	1,127		10			1,127		60
61	HEAT-ENERGY PANEL	1989	8,633		10			8,633		61
62	LEASEHOLD IMPROVEMENTS	1989	6,629		10			6,629		62
63	ROOF REPAIR	1990	6,928		10			2,928		63
64	REMODELING	1990	6,953	232	30	232		2,979		64
65	OVERHEAD DOOR	1990	1,220		10			1,220		65
66	KITCHEN TANKS	1990	3,089		10			3,089		66
67	PLASTERING	1990	2,586		10			2,586		67
68	REMODEL CEILING	1990	2,970		10			2,970		68
69	LEASEHOLD IMPROVEMENTS	1990	26,015		10			26,015		69
70	TOTAL (lines 4 thru 69)		\$ 4,680,031	\$ 5,465		\$ 112,274	\$ 106,809	\$ 2,681,259		70

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

Facility Name & ID Number Brother James Court

0020495

Report Period Beginning:

07/01/06

Ending:

06/30/07

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12A, Carried Forward	\$ 4,680,031	\$ 5,465		\$ 112,274	\$ 106,809	\$ 2,681,259		1
2	LEASEHOLD IMPROVEMENTS	1991 2,141		10			2,141		2
3	WINDOW REPLACEMENT	1992 2,750		10			2,750		3
4	CARETERIA DOORS	1993 11,918		10			11,918		4
5	PLUMBING WORK	1994 6,858		10			6,858		5
6	PAINTING	1995 3,076		10			3,076		6
7	WALL AND DOOR REPAIR	1995 2,596		10			2,596		7
8	DOOR	1996 656		10			656		8
9	ROOF REPAIR	1996 5,985		10			5,985		9
10	PAINTING	1996 1,620		3			1,620		10
11	FURNACE	1996 502		10			502		11
12	LAND IMPROVEMENTS	1996 1,385		3			1,385		12
13	REPAIRS	1996 10,702		5			10,702		13
14	GRIP CAPS	1996 1,575		5			1,575		14
15	BOILER	1996 3,335		10			3,335		15
16	BEDDING	1996 1,505		3			1,505		16
17	AIR DEFLECTORS	1996 381		3			381		17
18	SHOWER	1996 259		5			259		18
19	SEWER	1996 9,387		10			9,387		19
20	PAINTING	1996 4,928		10			4,928		20
21	ROOF REPAIR	1997 798	80	10	80		798		21
22	DRAPES	1997 4,500		5			4,500		22
23	FLOOR COVERINGS	1997 1,722	172	10	172		1,722		23
24	DRAPES - LIFE CENTER	1997 3,153		5			3,153		24
25	FLOOR COVERING - LIFE CENTER	1997 4,422	442	10	442		4,422		25
26	PAINTING - LIFE CENTER	1997 8,917	892	10	892		8,917		26
27	FLOOR	1997 2,658	157	10	157		2,658		27
28	ALARM/SMOKE DETECTORS	1998 20,108		5			20,108		28
29	SNACK LOUNGE REMODELING	1999 2,847		5			2,847		29
30	ROOF REPAIRS	1999 846	85	10	85		698		30
31	CARPET - FRONT OFFICE	1999 8,881		5			8,881		31
32	YARD SIGNS	1999 2,825	283	10	283		2,284		32
33	NEW TEES AND VALVES	1999 11,685	1,169	10	1,169		9,445		33
34	TOTAL (lines 1 thru 33)	\$ 4,824,952	\$ 8,745		\$ 115,554	\$ 106,809	\$ 2,823,251		34

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

Facility Name & ID Number Brother James Court

0020495

Report Period Beginning:

07/01/06

Ending:

06/30/07

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 4,824,952	\$ 8,745		\$ 115,554	\$ 106,809	\$ 2,823,251	1
2	VINYL WALL COVERING	1999	1,127	113	10	113		902	2
3	SHOWER ROOM REPAIRS	1999	8,220	822	10	822		6,576	3
4	CONNECTION FEES FOR SEWER PROJECT	1998	7,438	744	10	744		6,384	4
5	TREE REMOVAL	1999	9,857	986	10	986		7,721	5
6	CONDENSOR	1999	12,396	1,240	10	1,240		9,710	6
7	LEASEHOLD IMPROVEMENTS	1999	2,598		5			2,598	7
8	LANDSCAPING	1999	18,255	1,826	10	1,826		14,071	8
9	DROP ROD ASSEMBLY	1999	6,408	641	10	641		4,966	9
10	FENCING	1999	3,840	384	10	384		2,944	10
11	TREES	1999	9,905	991	10	991		7,511	11
12	ROOF REPAIRS	2000	2,300	230	10	230		1,687	12
13	TILE FLOOR - RESIDENT WING	2000	34,740	3,474	10	3,474		25,476	13
14	PAINTING	2000	6,352		5			6,352	14
15	WINDOW REPLACEMENT	2000	2,009	201	10	201		1,457	15
16	LEASEHOLD IMPROVEMENTS	2000	5,754		5			5,754	16
17	CABINET MODIFICATIONS	1999	4,520	323	7	323		4,520	17
18	PROFESSIONAL ELECTRICAL SERVICES	1999	17,410	1,161	15	1,161		9,285	18
19	NEW SIGN FRONT	1999	900		5			900	19
20	BJC - MASONRY WORK	1999	23,465	1,564	15	1,564		12,515	20
21	PROFESSIONAL PLUMBING AND HEATING	1999	3,100	2,067	15	2,067		16,533	21
22	REMODELING	1999	19,524	1,302	15	1,302		10,413	22
23	PARKING LOT STRIPING	2000	1,549		5			1,549	23
24	PAINT BASEMENT CEILING	2000	664		5			664	24
25	DRAPERIES	2001	10,881	317	5	317		10,881	25
26	RAMP AREA DECORATING	2001	14,387	240	5	240		14,387	26
27	PAINTING AND WALLCOVERING	2001	8,058	269	5	269		8,058	27
28	AIR CURTAIN	2001	1,812	259	7	259		1,510	28
29	RECEPTICLES - BEDROOMS	2001	9,820	655	5	655		9,820	29
30	SHOWER ROOM FLOOR REPAIRS	2002	1,123	112	10	112		618	30
31	DOOR REPAIRS	2002	6,197	620	10	620		3,317	31
32	BOILER REPAIRS	2002	3,960	396	5	396		3,960	32
33	DRAPERIES	2002	4,200	490	5	490		4,200	33
34	TOTAL (lines 1 thru 33)		\$ 5,087,721	\$ 30,172		\$ 136,981	\$ 106,809	\$ 3,040,490	34

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

STATE OF ILLINOIS

Facility Name & ID Number Brother James Court

0020495

Report Period Beginning:

07/01/06

Ending:

Page 12D

06/30/07

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	10
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12C, Carried Forward	\$ 5,087,721	\$ 30,172		\$ 136,981	\$ 106,809	\$ 3,040,490		1
2	ARCHITECT FEES - REMODEL BATHROOM AREAS	2002 9,863		3			9,863		2
3	REPAVE SIDEWALKS	2002 810	81	10	81		425		3
4	TUCKPOINTING	2002 1,490	149	10	149		770		4
5	REPAIR FLOORS	2002 2,688	269	10	269		1,389		5
6	KEYLOCK PAD	2002 580	58	10	58		285		6
7	STRIP AND REFINISH FLOORS	2002 8,702	870	10	870		4,082		7
8	HAT WATER STORAGE TANK	2002 4,408	441	10	441		1,984		8
9	DOORS AND FRAMES	2003 3,733	373	10	373		1,587		9
10	POLE LIGHTING - WEST PARKING LOT	2004 3,740	249	15	249		893		10
11	SINK FAUCET AND CABINET	2004 1,133	162	7	162		539		11
12	WALLPAPERING/PAINTING	2004 2,358	157	15	157		472		12
13	DOORS AND FRAMES	2004 4,987	332	15	332		1,053		13
14	CEILING FANS	2004 1,082	155	7	155		489		14
15	ELECTRICAL WORK	2004 16,000	1,067	15	1,067		3,200		15
16	ALARM SYSTEM	2004 2,204	315	7	315		945		16
17	BOILER - KITCHEN STEAMER	2004 4,871	696	7	696		2,204		17
18	BOILER	2004 6,900	986	7	986		3,368		18
19	BOILER	2004 7,200	1,029	7	1,029		3,086		19
20	TOILER ROOM ADDITION/RENOVATION	2003 699,826	23,328	30	23,328		82,361		20
21									21
22	HVAC LABOR/MATERIAL	2004 12,497	1,785	7	1,785		5,207		22
23	PARKING LOT	2004 74,847	2,495	30	2,495		7,277		23
24	DENTAL OFFICE RENOVATION	2004 57,955	1,932	30	1,932		5,313		24
25	POLE LIGHT REPLACEMENT	2004 1,868	267	7	267		712		25
26	PARKING LOT SECURITY SYSTEM	2005 20,404	2,915	7	2,915		7,278		26
27	STORAGE ROOM	2005 2,375	339	7	339		961		27
28									28
29	BATHROOM REPAIR	2006 4,232	846	5	846		1,622		29
30	ALARM FOR BUILDING	2006 3,000	300	10	300		525		30
31	ALARM FOR BUILDING	2006 3,041	304	10	304		481		31
32	ROOF	2006 22,370	1,119	20	1,119		1,771		32
33	WATER HEATER	2006 32,250	3,225	10	3,225		4,569		33
34	TOTAL (lines 1 thru 33)	\$ 6,105,135	\$ 76,416		\$ 183,225	\$ 106,809	\$ 3,195,201		34

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

Facility Name & ID Number Brother James Court

0020495

Report Period Beginning:

07/01/06

Ending:

06/30/07

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 12D, Carried Forward		\$ 6,105,135	\$ 76,416		\$ 183,225	\$ 106,809	\$ 3,195,201	1
2	BOILER	2007	4,611	439	7	439		439	2
3	BATHROOM REPAIES	2007	6,959	663	7	663		663	3
4	GENERATOR	2007	2,814	328	5	328		328	4
5	ALARM FOR BUILDING	2007	3,325	28	10	28		28	5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,122,844	\$ 77,874		\$ 184,683	\$ 106,809	\$ 3,196,659	34

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

Facility Name & ID Number Brother James Court

0020495

Report Period Beginning:

07/01/06

Ending:

06/30/07

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	\$ 239,784	\$ 31,994	\$ 31,994	\$		\$ 155,351	71
72	Current Year Purchases	7,936	636	636			636	72
73	Fully Depreciated Assets	1,482,497	29,345	29,345				73
74								74
75	TOTALS	\$ 1,730,217	\$ 61,975	\$ 61,975	\$		\$ 155,987	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility Use	Trucks	Various	\$ 72,449	\$ 336	\$ 336	\$	5	\$ 72,449	76
77	Resident Transportation	Vans/Wheelchair Lift	Various	70,019	1,187	1,187		5	35,611	77
78	Resident Transportation	Autos - Fully Depreciated	Various	39,323				5	39,323	78
79	Resident Transportation	Autos - 06 Buick/98 Buick	2006/2007	21,916	4,855	4,855		5	8,218	79
80	TOTALS			\$ 203,707	\$ 6,378	\$ 6,378	\$		\$ 155,601	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)	\$	8,056,768	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	146,227	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$	253,036	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	106,809	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$	3,508,247	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

10. Effective dates of current rental agreement:

Beginning 1975

Ending 2011

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

Fiscal Year Ending Annual Rent

12.	<u>6/30/2008</u>	\$ <u>270,000</u>
13.	<u>6/30/2009</u>	\$ <u>270,000</u>
14.	<u>6/30/2010</u>	\$ <u>270,000</u>

8. List separately any amortization of lease expense included on page 4, line 34. N/A

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: \$ NONE Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

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? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA <u>40</u></p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA <u>85</u></p>
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B. EXPENSES

ALLOCATION OF COSTS (d)

	Facility			
	1 Drop-outs	2 Completed	3 Contract	4 Total
1 Community College Tuition	\$	\$	\$	\$
2 Books and Supplies		270		270
3 Classroom Wages (a)		3,758		3,758
4 Clinical Wages (b)		7,797		7,797
5 In-House Trainer Wages (c)		4,028		4,028
6 Transportation				
7 Contractual Payments				
8 CNA Competency Tests				
9 TOTALS	\$	\$ 15,853	\$	\$ 15,853
10 SUM OF line 9, col. 1 and 2 (e)	\$	15,853		

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	10
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	10

- (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.

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		hrs	\$		\$		\$					\$	1
2	Licensed Speech and Language Development Therapist		hrs											2
3	Licensed Recreational Therapist		hrs											3
4	Licensed Physical Therapist		hrs											4
5	Physician Care		visits											5
6	Dental Care		visits											6
7	Work Related Program		hrs											7
8	Habilitation		hrs											8
9	Pharmacy		# of prescripts											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			\$		\$		\$		\$			\$	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.

STATE OF ILLINOIS

Facility Name & ID Number Brother James Court

0020495

Report Period Beginning: 07/01/06

Ending:

06/30/07

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/07

(last day of reporting year)

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	\$ 1,344,241	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	861,451		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	51,996		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,257,688	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments	1,340,258		12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	1,773,747		15
16	Equipment, at Historical Cost	1,890,689		16
17	Accumulated Depreciation (book methods)	(2,488,920)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,515,774	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,773,462	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 89,566	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	85,369		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>ACCRUED VACATION</u>	53,546		36
37	<u>ACCRUED PENSION, OTHER W/H</u>	78,196		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 306,677	\$	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)	\$ 306,677	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 4,466,785	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,773,462	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 4,078,772	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 4,078,772	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	\$ 388,013	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)	\$ 388,013	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)	\$ 4,466,785	24 *

* This must agree with page 17, line 47.

STATE OF ILLINOIS

Facility Name & ID Number Brother James Court

0020495

Report Period Beginning: 07/01/06

Ending:

Page 19

06/30/07

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	\$ 4,040,730	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,040,730	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	20,881	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	8,900	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 29,781	23
D. Non-Operating Revenue			
24	Contributions	283,744	24
25	Interest and Other Investment Income***	144,616	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 428,360	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	RENTAL INCOME	1,800	28
28a	MISC & NURSING INCOME	7,621	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 9,421	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,508,291	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	789,723	31
32	Health Care	1,697,877	32
33	General Administration	997,647	33
B. Capital Expense			
34	Ownership	416,227	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	218,804	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,120,278	40
41	Income before Income Taxes (line 30 minus line 40)**	388,013	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 388,013	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 Brother James Court

0020495

Report Period Beginning: 07/01/06

Ending:

06/30/07

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,912	2,067	\$ 52,968	\$ 25.63	1
2	Assistant Director of Nursing					2
3	Registered Nurses	79	79	1,541	19.51	3
4	Licensed Practical Nurses	16,037	17,092	288,927	16.90	4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,494	1,606	21,661	13.49	8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers	1,864	2,097	35,651	17.00	11
12	Dietician					12
13	Food Service Supervisor	2,048	2,156	39,084	18.13	13
14	Head Cook					14
15	Cook Helpers/Assistants	19,860	21,371	177,752	8.32	15
16	Dishwashers					16
17	Maintenance Workers	3,821	4,178	56,636	13.56	17
18	Housekeepers	3,904	4,342	52,035	11.98	18
19	Laundry	3,904	4,342	51,163	11.78	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative	12,574	13,680	204,110	14.92	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	7,416	8,023	101,536	12.66	28
29	Resident Services Coordinator	1,968	2,169	40,749	18.79	29
30	Habilitation Aides (DD Homes)	99,612	108,302	1,055,672	9.75	30
31	Medical Records	272	272	3,031	11.14	31
32	Other Health Care(specify)					32
33	Other(specify) Soc. Ser. Assist	336	380	4,411	11.61	33
34	TOTAL (lines 1 - 33)	177,101	192,156	\$ 2,186,927 *	\$ 11.38	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	100	\$ 3,887	1,3	35
36	Medical Director	Various	3,400	9,3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Various	3,300	10,3	39
40	Physical Therapy Consultant	195	10,739	10a,3	40
41	Occupational Therapy Consultant	25	1,112	10a,3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	15	363	11,3	44
45	Social Service Consultant	Various	6,000	12,3	45
46	Other(specify)				46
47	Psychology Consultant	Various	13,940	10a,3	47
48					48
49	TOTAL (lines 35 - 48)	334	\$ 42,740		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	\$		50
51	Licensed Practical Nurses			51
52	Certified Nurse Assistants/Aides			52
53	TOTAL (lines 50 - 52)	\$		53

