

Facility Name & ID Number St Andrew Life Center

0044776 Report Period Beginning: 07/01/2006 Ending: 06/30/2007

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	55	Intermediate (ICF)	55	20,075	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	55	TOTALS	55	20,075	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	
		Medicaid Recipient	Private Pay	Other		
8	SNF					8
9	SNF/PED					9
10	ICF	8,007	9,657		17,664	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	8,007	9,657		17,664	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.99%

D. How many bed-hold days during this year were paid by the Department? None (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 Note: 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: 06/30/2007 Fiscal Year: 06/30/2007
* 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: **07/01/2006** Ending: **06/30/2007**

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
1	A. General Services										
1	Dietary	439,621	34,791	2,446	476,858		476,858	(266,056)	210,802		1
2	Food Purchase		342,765		342,765		342,765	(212,661)	130,104		2
3	Housekeeping	204,677	6,321		210,998		210,998	(120,735)	90,263		3
4	Laundry	36,627	20,477		57,104		57,104	(33,359)	23,745		4
5	Heat and Other Utilities			313,273	313,273		313,273	(189,386)	123,887		5
6	Maintenance	165,162	30,346	168,915	364,423		364,423	(216,944)	147,479		6
7	Other (specify):*										7
8	TOTAL General Services	846,087	434,700	484,634	1,765,421		1,765,421	(1,039,141)	726,280		8
9	B. Health Care and Programs										
9	Medical Director			12,000	12,000		12,000		12,000		9
10	Nursing and Medical Records	881,552	43,236	320	925,108		925,108		925,108		10
10a	Therapy	37,533	327		37,860		37,860		37,860		10a
11	Activities	109,306	7,745	7,876	124,927		124,927		124,927		11
12	Social Services	49,662	49	2,200	51,911		51,911		51,911		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*	269,521	2,644	7,606	279,771		279,771	(279,771)			15
16	TOTAL Health Care and Programs	1,347,574	54,001	30,002	1,431,577		1,431,577	(279,771)	1,151,806		16
17	C. General Administration										
17	Administrative	92,548		444,640	537,188		537,188	(444,640)	92,548		17
18	Directors Fees										18
19	Professional Services			67	67		67		67		19
20	Dues, Fees, Subscriptions & Promotions			7,449	7,449		7,449		7,449		20
21	Clerical & General Office Expenses	224,387	17,395	45,341	287,123		287,123	291,388	578,511		21
22	Employee Benefits & Payroll Taxes			928,698	928,698		928,698	(172,427)	756,271		22
23	Inservice Training & Education										23
24	Travel and Seminar			3,057	3,057		3,057		3,057		24
25	Other Admin. Staff Transportation			1,195	1,195		1,195		1,195		25
26	Insurance-Prop.Liab.Malpractice			207,524	207,524		207,524		207,524		26
27	Other (specify):*										27
28	TOTAL General Administration	316,935	17,395	1,637,971	1,972,301		1,972,301	(325,679)	1,646,622		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,510,596	506,096	2,152,607	5,169,299		5,169,299	(1,644,591)	3,524,708		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.

Facility Name & ID Number St Andrew Life Center

#0044776

Report Period Beginning:

07/01/2006

Ending:

06/30/2007

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	
30	D. Ownership											
	Depreciation			467,594	467,594		467,594	(192,881)	274,713			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							5,934	5,934			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			5,075	5,075		5,075		5,075			35
36	Other (specify):*											36
37	TOTAL Ownership			472,669	472,669		472,669	(186,947)	285,722			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		161,870		161,870		161,870		161,870			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):* Non-allowable Cos			27,730	27,730		27,730	(27,730)				43
44	TOTAL Special Cost Centers		161,870	57,843	219,713		219,713	(27,730)	191,983			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,510,596	667,966	2,683,119	5,861,681		5,861,681	(1,859,268)	4,002,413			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

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	(5,446)	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	(27,730)	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 Pg. 5A	(1,830,164)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,863,340)		\$	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)	4,072		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 4,072		36
	(sum of SUBTOTALS)			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (1,859,268)		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

SEE ACCOUNTANTS' COMPILATION REPORT

St Andrew Life Center

ID#	<u>0044776</u>
Report Period Beginning:	<u>07/01/2006</u>
Ending:	<u>06/30/2007</u>

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Offset miscellaneous revenue	\$ (6,866)	21	1
2	Disallow assisted living wage	(269,521)	15	2
3	Disallow assisted living supplies	(2,587)	15	3
4	Disallow assisted living expenses	(7,663)	15	4
5	Disallow benefit allocated to assisted living	(276,488)	22	5
6	Disallow depreciation allocated to assisted living	(233,344)	30	6
7	Disallow maintenance expense allocated to assisted living	(216,944)	6	7
8	Disallow utilities expense allocated to assisted living	(189,386)	5	8
9	Disallow housekeeping allocated to assisted living	(120,735)	3	9
10	Disallow dietary wages allocated to assisted living	(266,056)	1	10
11	Disallow food expense allocated to assisted living	(207,215)	2	11
12	Disallow laundry expense allocated to assisted living	(33,359)	4	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	(1,830,164)		49

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Summary A

Facility Name & ID Number St Andrew Life Center# 0044776 Report Period Beginning:07/01/2006Ending: 06/30/2007

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(266,056)	0	0	0	0	0	0	0	0	0	0	(266,056)	1
2	Food Purchase	(212,661)	0	0	0	0	0	0	0	0	0	0	(212,661)	2
3	Housekeeping	(120,735)	0	0	0	0	0	0	0	0	0	0	(120,735)	3
4	Laundry	(33,359)	0	0	0	0	0	0	0	0	0	0	(33,359)	4
5	Heat and Other Utilities	(189,386)	0	0	0	0	0	0	0	0	0	0	(189,386)	5
6	Maintenance	(216,944)	0	0	0	0	0	0	0	0	0	0	(216,944)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(1,039,141)	0	0	0	0	0	0	0	0	0	0	(1,039,141)	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	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	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):*	(279,771)	0	0	0	0	0	0	0	0	0	0	(279,771)	15
16	TOTAL Health Care and Programs	(279,771)	0	0	0	0	0	0	0	0	0	0	(279,771)	16
	C. General Administration													
17	Administrative	0	(444,640)	0	0	0	0	0	0	0	0	0	(444,640)	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	(6,866)	298,254	0	0	0	0	0	0	0	0	0	291,388	21
22	Employee Benefits & Payroll Taxes	(276,488)	104,061	0	0	0	0	0	0	0	0	0	(172,427)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(283,354)	(42,325)	0	(325,679)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(1,602,266)	(42,325)	0	(1,644,591)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number St Andrew Life Center

0044776

Report Period Beginning:

07/01/2006 Ending:

06/30/2007

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)	
30	D. Ownership Depreciation	(233,344)	40,463	0	0	0	0	0	0	0	0	0	(192,881)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	5,934	0	0	0	0	0	0	0	0	0	5,934	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)	46,397	0	0	0	0	0	0	0	0	0	(186,947)	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):*	(27,730)	0	0	0	0	0	0	0	0	0	0	(27,730)	43
44	TOTAL Special Cost Centers	(27,730)	0	0	0	0	0	0	0	0	0	0	(27,730)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(1,863,340)	4,072	0	0	0	0	0	0	0	0	0	(1,859,268)	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
<u>Resurrection Health Care</u>	<u>100</u>	<u>See Attached</u>		<u>See Attached</u>		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	<u>21 Clerical & Data Processing</u>	\$	<u>Resurrection Health Care</u>	<u>100.00%</u>	<u>\$ 298,254</u>	<u>\$ 298,254</u>	<u>1</u>
2	V	<u>22 Employee Benefits</u>		<u>Resurrection Health Care</u>	<u>100.00%</u>	<u>104,061</u>	<u>104,061</u>	<u>2</u>
3	V	<u>30 Depreciation</u>		<u>Resurrection Health Care</u>	<u>100.00%</u>	<u>40,463</u>	<u>40,463</u>	<u>3</u>
4	V	<u>32 Interest</u>		<u>Resurrection Health Care</u>	<u>100.00%</u>	<u>5,934</u>	<u>5,934</u>	<u>4</u>
5	V							<u>5</u>
6	V							<u>6</u>
7	V	<u>17 Intercompany Accrual</u>	<u>444,640</u>	<u>Resurrection Health Care</u>	<u>100.00%</u>		<u>(444,640)</u>	<u>7</u>
8	V	<u>39 Intercompany Pharmacy</u>	<u>161,870</u>	<u>Resurrection Health Care</u>	<u>100.00%</u>	<u>161,870</u>		<u>8</u>
9	V							<u>9</u>
10	V							<u>10</u>
11	V							<u>11</u>
12	V							<u>12</u>
13	V							<u>13</u>
14	Total		<u>\$ 606,510</u>			<u>\$ 610,582</u>	<u>\$ * 4,072</u>	<u>14</u>

* 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: 07/01/2006 Ending: 06/30/2007

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	See attached pg. 7A								\$	1
2										2
3										3
4	Sister Elizabeth Trembczynski	Director	Board of Directors	0.00	93,368	<1 hour	<1%	N/A	N/A	N/A
5										5
6										6
7										7
8	Note: Sister Trembczynski was the administrator of Holy Family Nursing & Rehabilitation Center, a related facility									
9	from July 1, 2006 to April 30, 2007.									
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: 07/01/2006

Ending: 6/30/2007

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

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

Name of Related Organization Resurrection Health Care/Medical Center
 Street Address 7435 West Talcott
 City / State / Zip Code Chicago, IL 60631
 Phone Number (773) 774-8000
 Fax Number (773) 594-7488

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	21	Clerical & Data Processing			\$	\$		298,254	1
2	22	Employee Benefits						104,061	2
3	30	Depreciation						40,463	3
4	32	Interest						5,934	4
5									5
6									6
7	39	Intercompany Pharmacy						161,870	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				\$	\$		610,582	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	N/A					\$	\$				\$	1								
2												2								
3												3								
4												4								
5												5								
Working Capital																				
6	N/A											6								
7												7								
8												8								
9	TOTAL Facility Related					\$	\$				\$	9								
B. Non-Facility Related*																				
10	N/A											10								
11										Allocated from Home Office	5,934	11								
12												12								
13												13								
14	TOTAL Non-Facility Related					\$	\$				\$ 5,934	14								
15	TOTALS (line 9+line14)					\$	\$				\$ 5,934	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.)

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, please call the Bureau of Health Finance at (217) 782-1630.

2006 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 Cost

Enter the tax index number and real estate tax assessed for 2006 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 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. _____	<u>N/A</u>	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

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

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 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: 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	Resident Use	436,304	2000	\$ 2,600,000	1
2					2
3	TOTALS	436,304		\$ 2,600,000	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	\$	\$ 244,769
5									
6									
7									
8									
Improvement Type**									
9	Various		2000	5,782		20			
10									
11	Vacuum return system (20320)		2001	5,588		20			
12	Boiler bottom (21955)		2001	6,038		20			
13	Cross-header shaft (550)		2001	151		20			
14	T&M Rebuilt (840)		2001	231		20			
15	Plumbing (536)		2001	147		20			
16	Bathroom light diffuser (510)		2001	140		20			
17	Draperies (4300)		2001	1,183		20			
18	Vertical blinds (1638)		2001	450		20			
19	Circuit breaker (1519)		2001	418		20			
20	Limestone repair (32000)		2001	8,800		20			
21	Roof (7800)		2001	2,145		20			
22	Elevator (47332)		2001	13,016		20			
23	Pumps with new HP monitor(15965) - Alloc RHC		2001	4,390		20			
24	Water leak & insulate (1817) - Alloc RHC		2001	500		20			
25	Water gaskets (1063)		2002	292		20			
26	Astro-slide (606)		2002	166		20			
27	Hot water pump (618)		2002	170		20			
28	Welling pump (1568)		2002	431		20			
29	Landscaping (13550)		2002	3,726		20			
30	Land study (4175)		2002	1,148		20			
31	Code review (9772)		2002	2,687		20			
32	Land study (6925)		2002	1,904		20			
33	Electrical elevator (8494)		2002	2,336		20			
34	Carpet (1438)		2002	395		20			
35	Fire alarm (6771)		2002	1,862		20			
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:

07/01/2006

Ending:

06/30/2007

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. Svst-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	\$	\$ 244,769		70

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:

07/01/2006

Ending:

06/30/2007

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		\$ 244,769		1
2	Lifeline response systems (69,519)	2003 19,118		20					2
3	Install new floor & base (4071)	2003 1,120		20					3
4	Demolition (23,200) **	2003 6,380		20					4
5	Prof. serv - Code Review (50) **	2003 14		20					5
6	Furnish wood doors hardware (2288) **	2003 629		20					6
7	Elevator safety tests (4321) **	2003 1,188		20					7
8	Radio system (786) **	2003 216		20					8
9	Filters (826)	2003 227		20					9
10									10
11	Code review	2003 205		20					11
12	Land study	2003 6,743		20					12
13	Appraisal	2004 9,000		20					13
14	Rebuild fire box for boiler	2004 7,250		20					14
15	Data cable installation	2004 2,148		20					15
16	Convent demolition	2004 242,028		20					16
17	Asbestos removal	2004 49,460		20					17
18									18
19	Reseal, stripe parking lot	2005 6,975		10					19
20	Landscaping	2005 10,200		10					20
21	Boiler upgrade	2005 77,205		10					21
22	Roof work	2005 126,868		15					22
23	Utility station - cabinets, flooring, counter tops	2005 29,402		10					23
24	Replace tube bundles	2005 32,450		15					24
25	Furnace stack, hot & chilled water piping	2005 62,392		15					25
26	Stairwell doors	2005 18,121		15					26
27	Safety sensors - front entrance doors	2005 2,468		10					27
28	Emergency boiler repairs	2005 2,965		10					28
29	Wiring	2005 14,300		20					29
30	Flooring tile & installation	2005 11,650		10					30
31	Architectural & planning services from Loeb	2005 250,200		15					31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 2,097,219	\$ 24,021		\$ 24,021		\$ 244,769		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:

07/01/2006

Ending:

06/30/2007

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	\$	\$ 244,769	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	Entrvway medallion	2006	1,668		15				12
13	Cut & removal of 4 dead trees	2006	1,000		7				13
14	Landscape planting at main entrance w/signs	2006	5,000		7				14
15	Pruning & trimming of trees on northside	2006	2,800		5				15
16	Plants	2006	111		5				16
17	Plants	2007	1,079		5				17
18	Landscaping design & architectural services	2007	10,588		10				18
19	Landscape work	2007	425		5				19
20	Custom millwork	2007	5,980		15				20
21	Architectural Services	2007	214,651		20				21
22	Fire alarm upgrade	2007	504,785		20				22
23	Fire department connection charge	2007	150		20				23
24	Fee for professional services-remodeling	2007	2,736		20				24
25	System sales radio	2007	1,495		20				25
26	System sales undetermined	2007	744		20				26
27	Architectural Services	2007	35,135		20				27
28	Architectural Services	2007	11,262		20				28
29	General conditions	2007	485,766		20				29
30	Demolition	2007	172,618		20				30
31	Excavation	2007	7,530		20				31
32	Site concrete	2007	108,898		20				32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,705,719	\$ 24,021		\$ 24,021	\$	\$ 244,769	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 12C, Carried Forward	\$ 3,705,719	\$ 24,021		\$ 24,021		\$ 244,769		1
2	Landscaping	2007 27,853		20					2
3	Concrete	2007 15,446		20					3
4	Masonry	2007 89,192		20					4
5	Miscellaneous Metals	2007 51,971		20					5
6	Handrails & railings	2007 13,230		20					6
7	Millwork	2007 343,428		20					7
8	Firecaulking	2007 8,545		20					8
9	Custom aluminum panels	2007 18,980		20					9
10	Sealants & caulking	2007 4,600		20					10
11	Doors, frames & hardware	2007 100,201		20					11
12	Aluminum entrances & glazing	2007 64,784		20					12
13	Automatic doors	2007 5,571		20					13
14	Drywall & plaster	2007 739,174		20					14
15	Ceramic tile	2007 80,178		20					15
16	Terrazzo & refinishing	2007 60,227		20					16
17	Flooring	2007 359,579		20					17
18	Painting	2007 338,126		20					18
19	Temporary structures and coverings	2007 11,700		20					19
20	Interior signage	2007 23,147		20					20
21	Acoustical partitions	2007 2,943		20					21
22	Toilet accessories	2007 24,917		20					22
23	Plumbing & HVAC	2007 555,112		20					23
24	Fire protection	2007 103,248		20					24
25	Electrical	2007 859,463		20					25
26	Permit allowance	2007 802		20					26
27	Change orders fees	2007 1,662		20					27
28	Project management fees	2007 198,984		20					28
29	Contractor contingency	2007 3,095		20					29
30	GLC insurance	2007 48,200		20					30
31	Sub-default insurance	2007 37,430		20					31
32	Allocated from Home Office				40,463	40,463			32
33	Financial statement depreciation		158,037		158,037		345,590		33
34	TOTAL (lines 1 thru 33)	\$ 7,897,507	\$ 182,058		\$ 222,521	\$ 40,463	\$ 590,359		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	\$ 477,553	\$ 31,710	\$ 31,710		10	\$ 191,474	71
72	Current Year Purchases	532,285	20,482	20,482		5-15	20,482	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,009,838	\$ 52,192	\$ 52,192			\$ 211,956	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 11,507,345	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 234,250	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 274,713	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 40,463	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 802,315	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	1,577,145	89
90					90
91	TOTALS	\$ 3,475,896	\$ 233,344	\$ 1,577,145	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Andrew Life Center

0044776

Report Period Beginning: 07/01/2006

Ending: 06/30/2007

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

**

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

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____*

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 5,075 Description: Copier-\$2500, Postage Meter-\$902, Cell Phone-\$1673

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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. /2008 \$ _____

13. /2009 \$ _____

14. /2010 \$ _____

* 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

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 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			
	1	2	3	4
	Drop-outs	Completed	Contract	Total
1 Community College Tuition	\$	\$	\$	\$
2 Books and Supplies				
3 Classroom Wages (a)				
4 Clinical Wages (b)				
5 In-House Trainer Wages (c)				
6 Transportation				
7 Contractual Payments				
8 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.)

1	Service	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	5					
					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) & (2)	1066 hrs	37,533			327	1,066	37,860	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				161,870		161,870	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			\$ 37,533		\$	\$ 162,197	1,066	\$ 199,730	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

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	\$ 8,450	\$ 8,450	1
2 Cash-Patient Deposits			2
3 Accounts & Short-Term Notes Receivable-Patients (less allowance 158,376)	61,987	61,987	3
4 Supply Inventory (priced at)			4
5 Short-Term Investments			5
6 Prepaid Insurance			6
7 Other Prepaid Expenses	5,022	5,022	7
8 Accounts Receivable (owners or related parties)			8
9 Other(specify): Security Deposit	22,944	22,944	9
TOTAL Current Assets (sum of lines 1 thru 9)	\$ 98,403	\$ 98,403	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	10,403,927	936,802	14
15 Leasehold Improvements, at Historical Cos	110,749	6,960,705	15
16 Equipment, at Historical Cost	1,759,386	1,009,838	16
17 Accumulated Depreciation (book methods)	(2,379,461)	(802,315)	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 (specify):			22
23 Other(specify):			23
TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 12,496,205	\$ 10,706,634	24
TOTAL ASSETS (sum of lines 10 and 24)	\$ 12,594,608	\$ 10,805,037	25

	1	2	
	Operating	After Consolidation*	
C. Current Liabilities			
26 Accounts Payable	\$ 170,177	\$ 170,177	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 Due to Related Parties	7,148,310	7,148,310	36
37			37
TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 7,318,487	\$ 7,318,487	38
D. Long-Term Liabilities			
39 Long-Term Notes Payable			39
40 Mortgage Payable			40
41 Bonds Payable			41
42 Deferred Compensation			42
Other Long-Term Liabilities(specify):			
43			43
44			44
TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 7,318,487	\$ 7,318,487	46
47 TOTAL EQUITY (page 18, line 24)	\$ 5,276,121	\$ 3,486,550	47
TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 12,594,608	\$ 10,805,037	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 5,687,283	1
2	Restatements (describe):		2
3	Prior period adjustment	(50,061)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 5,637,222	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(361,101)	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)	\$ (361,101)	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)	\$ 5,276,121	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

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	\$ 5,865,459	1
2	Discounts and Allowances for all Levels	(811,481)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,053,978	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	117,846	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 117,846	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		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	5,446	14
15	Telephone, Television and Radic		15
16	Rental of Facility Space	15,568	16
17	Sale of Drugs	189,021	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	99,642	21
22	Laundry	1,716	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 311,393	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			28
28a	<u>Miscellaneous Revenue</u>	17,363	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 17,363	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,500,580	30

2

Expenses		Amount	
A. Operating Expenses			
31	General Services	1,765,421	31
32	Health Care	1,431,577	32
33	General Administration	1,972,301	33
B. Capital Expense			
34	Ownership	472,669	34
C. Ancillary Expense			
35	Special Cost Centers	189,600	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)*	\$ 5,861,681	40
41	Income before Income Taxes (line 30 minus line 40)**	(361,101)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (361,101)	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
7/1/2006 - 6/30/2007

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

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	1,784	2,180	\$ 78,860	\$ 36.17	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,125	4,781	147,276	30.80	3
4	Licensed Practical Nurses	8,290	9,326	229,830	24.64	4
5	CNAs & Orderlies	25,447	28,107	425,586	15.14	5
6	CNA Trainees					6
7	Licensed Therapist	772	961	37,533	39.06	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,872	2,120	47,428	22.37	9
10	Activity Assistants	3,679	4,102	61,878	15.08	10
11	Social Service Workers	1,744	2,080	49,662	23.88	11
12	Dietician	190	190	6,699	35.26	12
13	Food Service Supervisor	1,764	1,880	54,754	29.12	13
14	Head Cook	6,854	7,621	107,728	14.14	14
15	Cook Helpers/Assistants	24,171	27,387	270,440	9.87	15
16	Dishwashers					16
17	Maintenance Workers	8,370	9,449	165,162	17.48	17
18	Housekeepers	15,830	17,896	204,677	11.44	18
19	Laundry	3,223	3,557	36,627	10.30	19
20	Administrator	1,788	1,960	92,548	47.22	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,655	10,778	224,387	20.82	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>	18,150	20,250	269,521	13.31	33
34	TOTAL (lines 1 - 33)	137,708	154,625	\$ 2,510,596 *	\$ 16.24	34

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	44 2,200	12(3)	45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	44 \$ 14,200		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

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	
Nancy Mella-Oliver	Administrator	0	\$ 92,548	Workers' Compensation Insurance	\$ 36,230	IDPH License Fee	\$ 995	
				Unemployment Compensation Insurance	5,964	Advertising: Employee Recruitment		
				FICA Taxes	172,189	Health Care Worker Background Check		
				Employee Health Insurance	472,543	(Indicate # of checks performed <u>1</u>)	58	
				Employee Meals		Patient Background Checks <u>3</u>	48	
				Illinois Municipal Retirement Fund (IMRF)*		Life Services Network of Illinois dues	5,167	
				Employee Life Insurance	11,269	Miscellaneous Dues & Subscriptions	1,181	
				Employee Disability Insurance	13,681			
				Employee Retirement	191,710			
				Employee Dental Insurance	15,122			
				Employee Morale & Other Benefits	9,990	Less: Public Relations Expense	()	
				Allocated from Home Office	104,061	Non-allowable advertising	()	
				Less: Nonallowable non-care benefits	(276,488)	Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 92,548	TOTAL (agree to Schedule V, line 22, col.8)		\$ 7,449		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Management Fee			\$ 444,640	N/A			Out-of-State Travel	\$
(Eliminated on Sch. V, Line 17, Col 3)								
							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 444,640				Seminar Expense	
							See Attached	3,057
C. Professional Services								
Vendor/Payee	Type		Amount				Entertainment Expense	()
Ka Elster	Legal		\$ 67				(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 3,057
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 67	TOTAL		\$		

* 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	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012
1	N/A	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
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

Facility Name & ID Number St Andrew Life Center

0044776

Report Period Beginning: 07/01/2006

Ending: 06/30/2007

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 - \$5,167
- (3) Did the nursing home make political contributions or payments to a political organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 12.5 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 16,575 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 benefit on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 5,446
- (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: KPMG 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 \$5,000, have legal invoices and a summary of service 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: 7/01/06 - 6/30/07
 A. Springborn

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	440,097	60.45%	266,056
Food	342,765	60.45%	207,215
Hskpg	199,714	60.45%	120,735
Laundry	55,181	60.45%	33,359
Utilities	313,273	60.45%	189,386
Maintenance	358,859	60.45%	216,944
Employee Benefits	928,698	(B)	276,488
Miscellaneous Revenue	(17,363)	60.45%	(10,497)
Depreciation	467,594	SALY	233,344
			1,533,029

(A)

Census:	Assisted Living	29,331
Census:	Total	48,518
	Allocation %	60.45%

(B)

Employee benefits	928,698		
Total wages	2,510,593		
% of total wages	36.99%		
<u>Wages from which to allocate EE Benefits</u>			
Dietary	402,860		
Housekeeping	193,393		
Laundry	34,704		
Maintenance	159,598		
total	790,555	60.45%	477,921
Assisted Living	269,521	100.00%	269,521
			747,442
			0.3699
			276,488