

Facility Name & ID Number St Francis Nursing & Rehab Center

0044370 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 08/21/2006

	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	78	Skilled (SNF)	124	42,914	1
2		Skilled Pediatric (SNF/PED)			2
3	46	Intermediate (ICF)		2,346	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	124	TOTALS	124	45,260	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	
		Medicaid Recipient	Private Pay	Other		Total
8	SNF	8,134	1,965	9,013	19,112	8
9	SNF/PED					9
10	ICF	15,472	2,267		17,739	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	23,606	4,232	9,013	36,851	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.42%

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

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO 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 03/08/1985

J. Was the facility purchased or leased after January 1, 1978?
YES Date 03/08/1985 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 78 and days of care provided 9,013

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year YES NO

Tax Year: 06/30/07 Fiscal Year: 06/30/07

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

Resurrection Life Center
 BED DAYS AVAILABLE
 FYE: 06/30/07

Schedule 2A

	CERTIFIED SECTION	NON CERT. SECTION	TOTAL HOUSE
07/01/06 - 08/20/06			
NUMBER OF BEDS	78	46	124
DAYS IN REPORTING PERIOD	51	51	51
TOTAL BEDS FOR PERIOD #1	3,978	2,346	6,324
08/21/06 - 06/30/07			
NUMBER OF BEDS	124		124
DAYS IN REPORTING PERIOD	314		314
TOTAL BEDS FOR PERIOD #2	38,936	0	38,936
TOTAL BED DAYS AVAILABLE	42,914	2,346	45,260

STATE OF ILLINOIS

Facility Name & ID Number St Francis Nursing & Rehab Center # 0044370 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	320,141	33,746	5,363	359,250		359,250		359,250		1
2	Food Purchase		230,447		230,447		230,447	(4,102)	226,345		2
3	Housekeeping	136,251	26,751	4,778	167,780		167,780		167,780		3
4	Laundry	30,894	211,439		242,333		242,333		242,333		4
5	Heat and Other Utilities			129,039	129,039		129,039		129,039		5
6	Maintenance	50,539	12,340	96,531	159,410		159,410		159,410		6
7	Other (specify):*										7
8	TOTAL General Services	537,825	514,723	235,711	1,288,259		1,288,259	(4,102)	1,284,157		8
	B. Health Care and Programs										
9	Medical Director			27,528	27,528		27,528		27,528		9
10	Nursing and Medical Records	2,446,045	133,788	53,463	2,633,296		2,633,296		2,633,296		10
10a	Therapy	345,270	4,637	26,734	376,641		376,641		376,641		10a
11	Activities	127,954	13,539	16,550	158,043		158,043		158,043		11
12	Social Services	45,437	198	1,978	47,613		47,613		47,613		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,964,706	152,162	126,253	3,243,121		3,243,121		3,243,121		16
	C. General Administration										
17	Administrative	108,367		478,051	586,418		586,418	(478,051)	108,367		17
18	Directors Fees										18
19	Professional Services			794	794		794		794		19
20	Dues, Fees, Subscriptions & Promotion			20,256	20,256		20,256		20,256		20
21	Clerical & General Office Expense	166,629	28,392	7,422	202,443		202,443	416,955	619,398		21
22	Employee Benefits & Payroll Tax			1,194,849	1,194,849		1,194,849	153,062	1,347,911		22
23	Inservice Training & Education										23
24	Travel and Semina			2,112	2,112		2,112	(531)	1,581		24
25	Other Admin. Staff Transportatior			35,676	35,676		35,676		35,676		25
26	Insurance-Prop.Liab.Malpractice			214,002	214,002		214,002		214,002		26
27	Other (specify):*										27
28	TOTAL General Administration	274,996	28,392	1,953,162	2,256,550		2,256,550	91,435	2,347,985		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,777,527	695,277	2,315,126	6,787,930		6,787,930	87,333	6,875,263		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 Francis Nursing & Rehab Center

#0044370

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	
	D. Ownership											
30	Depreciation			355,589	355,589		355,589	56,563	412,152			30
31	Amortization of Pre-Op. & Org											31
32	Interest							8,295	8,295			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicle:			54,396	54,396		54,396		54,396			35
36	Other (specify): ³											36
37	TOTAL Ownership			409,985	409,985		409,985	64,858	474,843			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportatior											38
39	Ancillary Service Center:		988,472		988,472		988,472		988,472			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shop:											41
42	Provider Participation Fee			67,890	67,890		67,890		67,890			42
43	Other (specify): ³ Non-allowable Cos			894	894		894	(894)				43
44	TOTAL Special Cost Centers		988,472	68,784	1,057,256		1,057,256	(894)	1,056,362			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,777,527	1,683,749	2,793,895	8,255,171		8,255,171	151,297	8,406,468			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

Facility Name & ID Number St Francis Nursing & Rehab Center

0044370

Report Period Beginning:

07/01/2006

Ending:

06/30/2007

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 Program				3
4	Non-Patient Meals	(4,102)	2		4
5	Telephone, TV & Radio in Resident Room				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patient				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refund				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 Transaction				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 Retainer				22
23	Malpractice Insurance for Individual				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employee				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg. 5A	(1,394)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (5,496)		\$	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)	156,793		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 156,793		36
	(sum of SUBTOTALS)			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ 151,297		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 Shop		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 Francis Nursing & Rehab Center

ID# 0044370

Report Period Beginning: 07/01/2006

Ending: 06/30/2007

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Disallow non-allowable marketing expense	\$ (894)	43	1
2	Disallow out of state travel expense	(500)	24	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	(1,394)		49

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Summary A

Facility Name & ID Number St Francis Nursing & Rehab Center

0044370

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

	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	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(4,102)	0	0	0	0	0	0	0	0	0	0	(4,102)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(4,102)	0	0	0	0	0	0	0	0	0	0	(4,102)	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):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(478,051)	0	0	0	0	0	0	0	0	0	(478,051)	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	0	416,924	0	0	0	0	0	0	0	0	0	416,924	21
22	Employee Benefits & Payroll Taxes	0	153,062	0	0	0	0	0	0	0	0	0	153,062	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(500)	0	0	0	0	0	0	0	0	0	0	(500)	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	(500)	91,935	0	91,435	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(4,602)	91,935	0	87,333	29								

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Resurrection Health Care		See attached		See attached		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: 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	21 Clerical & data processing	\$	Resurrection Health Care	100.00%	\$ 416,924	\$ 416,924	1
2	V	22 Employee benefits		Resurrection Health Care	100.00%	153,062	153,062	2
3	V	30 Depreciation		Resurrection Health Care	100.00%	56,563	56,563	3
4	V	32 Interest		Resurrection Health Care	100.00%	8,295	8,295	4
5	V							5
6	V							6
7	V	17 Intercompany Expense	478,051	Resurrection Health Care	100.00%		(478,051)	7
8	V	39 Intercompany Pharmacy	988,472	Resurrection Health Care	100.00%	988,472		8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,466,523			\$ 1,623,316	\$ * 156,793	14

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

Facility Name & ID Number St Francis Nursing & Rehab Center # 0044370 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 page 7A								\$	1	
2										2	
3										3	
4	Sister Elizabeth Trembczynsk	Director	Board of Directors	0.00	93,368	1	2.00	N/A	N/A	N/A	
5										5	
6	Sister Elizabeth Trembczynski was the administrator for Holy Family Nursing and Rehabilitation Center, a related entity, from July 1, 20										6
7	through April 30, 2007.										7
8										8	
9										9	
10										10	
11										11	
12										12	
13								TOTAL	\$	13	

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Francis Nursing & Rehab Center # 0044370 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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	21	Clerical & data processing			\$	\$		416,924	1
2	22	Employee benefits						153,062	2
3	30	Depreciation						56,563	3
4	32	Interest						8,295	4
5									5
6									6
7									7
8	39	Intercompany Pharmaci						988,472	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				\$	\$		1,623,316	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **St Francis Nursing & Rehab Center**# **0044370**

Report Period Beginning:

07/01/2006

Ending:

06/30/2007**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
						Amount of Note					
Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Original	Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	YES	NO									
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								Allocated from Home Office			8,295
12											12
13											13
14	TOTAL Non-Facility Related					\$	\$			\$	8,295
15	TOTALS (line 9+line14)					\$	\$			\$	8,295

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 Francis Nursing & Rehab Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0044370

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. _____	_____	\$ _____	\$ _____
2. _____	N/A _____	\$ _____	\$ _____
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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Francis Nursing & Rehab Center

0044370 Report Period Beginning:

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 51,712 B. General Construction Type: Exterior Brick Frame _____ 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, et

List entity name, type of business, square footage, and number of beds/units available (where applicable)

None

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

1. Total Amount Incurred: 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: N/A
(Attach a complete schedule detailing the total amount of organization and pre-operating costs)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Resident Care</u>		<u>1985</u>	\$ <u>188,421</u>	<u>1</u>
2					<u>2</u>
3	TOTALS			\$ <u>188,421</u>	<u>3</u>

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Francis Nursing & Rehab Center

0044370

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		
Bed* ^s	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	124	1985	1961	\$ 2,426,118	\$ 80,660	30	\$ 80,660	\$	\$ 1,821,173	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	General Construction/Renovation		1986	12,875		12			12,875	9
10	General Construction/Renovation		1986	3,543		10			3,543	10
11	General Construction/Renovation		1986	82,489		15			82,489	11
12	General Construction/Renovation		1986	44,717		20			44,717	12
13	General Construction/Renovation		1987	5,529		12			5,529	13
14	General Construction/Renovation		1987	2,560		10			2,560	14
15	Inhouse Labor		1988	7,688		5			7,688	15
16	Shower		1989	3,836	192	20	192		3,549	16
17	Lobby Refurbish/Exterior Renovation		1991	73,428		5			73,428	17
18	Dishwasher and Installation		1991	7,332		10			7,332	18
19	Sidewalk Replacement		1991	4,880		5			4,880	19
20	Remodel		1993	30,862	2,057	15	2,057		29,831	20
21	Vestibule: Wallpaper/Painting; Window Draperies		1996	4,601	307	15	307		3,375	21
22	Combustion Air Handling System		1996	24,969		10			24,969	22
23	Fire Alarm System		1996	71,668		10			71,668	23
24	Parking Lot Repaving		1997	7,162	477	15	477		4,793	24
25	Roofing: Drain flashing collar; coping replacement									25
26	deck repair; masonry repointing; install new drains		1997	74,400	4,960	15	4,960		49,807	26
27	Admin offices: carpeting; wallpapering & painting;									27
28	electrical wiring and lighting		1997	12,270	818	15	818		8,214	28
29	Renovate 3 Nursing Floors: painting & wallpapering;									29
30	install ADA handles & mirrors; carpeting & floor									30
31	tiling; installation of glass blocks & window									31
32	masonry; installation and modification of light									32
33	fixtures; plumbing & H.V.A.C. sprinklers		1997	499,653	33,310	15	33,310		334,489	33
34	Security Camera System		1997	16,014	1,535	10	1,535		16,014	34
35	Parking Lot Repaving		1999	8,530	569	15	569		4,835	35
36										36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Francis Nursing & Rehab Center

0044370

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									37
38									38
39									39
40									40
41	1999	23,212	2,263	10	2,263		19,235		41
42	1999	118,907	7,927	15	7,927		67,380		42
43	2000	7,400	493	15	493		3,699		43
44	2000	21,493	1,433	15	1,433		10,747		44
45	2000	8,058	576	7	576		8,058		45
46									46
47									47
48									48
49									49
50									50
51	2000	190,424	19,042	10	19,042		142,817		51
52									52
53	2001	4,606		5			4,606		53
54	2001	2,674		5			2,674		54
55									55
56	2001	1,350	193	7	193		1,254		56
57	2001	9,720		5			9,720		57
58									58
59									59
60									60
61	2001	56,042	5,604	10	5,604		36,427		61
62	2002	536,437	34,878	15	34,878		191,828		62
63	2002	30,000	4,286	7	4,286		23,572		63
64	2002	21,710	3,101	7	3,101		17,057		64
65	2002	5,084	708	7	708		3,895		65
66	2002	10,439	1,754	5	1,754		10,439		66
67									67
68									68
69									69
70		\$ 4,472,680	\$ 207,143		\$ 207,143	\$	\$ 3,171,166		70

SEE ACCOUNTANTS' COMPILATION REPORT

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

STATE OF ILLINOIS

Page 12B

Facility Name & ID Number St Francis Nursing & Rehab Center

0044370

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	\$ 4,472,680	\$ 207,143		\$ 207,143	\$	\$ 3,171,166		1
2	is activated by smoke detectors, pull stations and sprinkle								2
3	system; installation of smoke operated fire dampers and								3
4	access panels in exhaust duct system penetrating smoke								4
5	barrier walls located on floors 1, 2 and 3.	2002	481,852	46,597	10	46,597		256,283	5
6	Interior renovation - includes but not limited to								6
7	Toli floor and ramp; carpet administration area; switch								7
8	bank for lobby and entrance area; new light fixtures in								8
9	various area; replace piping to boilers; new condensin								9
10	unit to north window well; reheat coil in lobby; replac								10
11	bathroom fixtures; replace/upgrade ceiling in various area								11
12	various wall modifications; replace various bathroom								12
13	fixtures; various other electrical and plumbin								13
14	modifications.	2002	159,709	16,549	10	16,549		91,021	14
15	Exterior renovation - includes not limited to: sliding doors								15
16	removal and replacement of concrete curbs; paving								16
17	grading and stonework; install new fire ceiling and fram								17
18	in smoking area; new handicap signs; various electric								18
19	work in outside waiting area (includes new heaters								19
20	intercom and doorbell).	2002	98,000	6,533	15	6,533		35,932	20
21	Lobby renovation - includes but not limited to: selectiv								21
22	demolition of existing lobby, toilet room, and reception								22
23	and replacement of each as well as new assisted bathing								23
24	this includes new partitions, electric plumbing, HVAC								24
25	acoustic panel ceiling, floor finishes, doors, frames,								25
26	interior windows and casement. Floral fixtures and								26
27	artwork.	2002	166,549	11,732	14	11,732		64,527	27
28	Acquisition/installation of medical records voice and dat								28
29	cables, 24-port patch panel, and fire stop & sleeves	2003	4,646	310	15	310		1,395	29
30	2 sewage pumps	2003	5,752	383	15	383		1,724	30
31	Down light style fixtures-acquisition and electrical wor	2003	3,780	252	15	252		1,134	31
32	Elevator control valve piping	2003	10,037	1,004	10	1,004		4,518	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,403,005	\$ 290,503		\$ 290,503	\$	\$ 3,627,700	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 Francis Nursing & Rehab Center

0044370

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	\$ 5,403,005	\$ 290,503		\$ 290,503	\$	\$ 3,627,700		1
2	Remove existing and install new nurse station (1st floor)	2004 8,300	553	15	553		1,936		2
3	Purchase & install quarry tile in kitchen entranc	2004 1,114	223	5	223		780		3
4	Grout kitchen floor	2004 4,740	474	10	474		1,659		4
5	Purchase & install raised round rubber tiles in elevato	2004 1,538	308	5	308		1,078		5
6	Purchase & install 2 ceiling 40-gallon ASME codec								6
7	expansion tanks	2004 3,685	737	5	737		2,580		7
8	Purchase & install hot water heate	2004 3,250	216	15	216		756		8
9	Purchase & install category 5E wire cable in elevato	2004 758	76	10	76		266		9
10	Replace wood floor with concrete in oxvgen storage close	2004 1,750	116	15	116		406		10
11									11
12	Carpet for lobby and chape	2005 4,730	158	5	158		395		12
13	Overhead domestic water lin	2005 1,075	18	10	18		45		13
14	Replace main drain & rod sewer	2005 3,052	34	15	34		85		14
15	Elevator upgrad	2005 6,184	102	10	102		255		15
16	Lever drains in three compartment sink	2005 1,744	28	10	28		70		16
17	Baxtor Flo Guard Pump	2005 5,973	160	10	160		400		17
18									18
19	Phase 2 Fireman's Recall	2006 59,921	3,995	15	3,995		5,817		19
20	Upgrade electrical feed for reznor roof top uni	2006 12,950	1,295	10	1,295		1,943		20
21	Replace sprinkler heads in kitcher	2006 2,137	214	10	214		321		21
22	Replace ceiling tiles in kitcher	2006 2,300	153	15	153		230		22
23	Mixer bench gear drive 20qt	2006 3,820	255	15	255		382		23
24	Vulcan Range 60" burner 20" griddle gas typ	2006 3,945	395	10	395		592		24
25	Replace window & glaz	2006 4,765	318	15	318		477		25
26	Combination Lennox make up air uni	2006 15,000	1,500	10	1,500		2,250		26
27	50 pair cable to north & south wings	2006 4,617	308	15	308		462		27
28	Relavs, transformers & t-stats on boile	2006 2,500	250	10	250		375		28
29	Elevator upgrad	2006 14,625	1,462	10	1,462		2,193		29
30									30
31	Replace Concrete	2006 7,100	237	15	237		237		31
32	Furnish & Install Fire Rated Wood Doors	2006 2,741	91	15	91		91		32
33	Furnish & Install New Door in Receiving Are	2006 4,230	141	15	141		141		33
34	TOTAL (lines 1 thru 33)	\$ 5,591,549	\$ 304,320		\$ 304,320	\$	\$ 3,653,922		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	\$ 5,591,549	\$ 304,320		\$ 304,320		\$ 3,653,922		1
2	Inspect & Install 3 Fire Dampers & 3 Access Panels	2006 5,049	252	10	252		252		2
3	Remove & Replace tile around sink & paint ceiling in rooms 303 &	2007 3,958	220	8-10	220		220		3
4	Install 6" RPZ valve on fire sprinkler system	2006 7,000	350	10	350		350		4
5	Replace Sprinkler Heads on Floors 1, 2 & 3	2007 3,439	246	7	246		246		5
6	Replace voice cable on 3rd Floor	2007 14,994	1,071	7	1,071		1,071		6
7	35 American Standard - Mader:	2007 6,475	463	7	463		463		7
8	Electrical work	2007 6,885	430	8	430		430		8
9	Ceiling Tile Toilet Repair Kits	2007 12,400	775	8	775		775		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	Allocated from Home Office				56,563	56,563			30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 5,651,749	\$ 308,127		\$ 364,690	\$ 56,563	\$ 3,657,729		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 instruction

	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	\$ 783,631	\$ 43,877	\$ 43,877	\$	5-15	\$ 597,388	71
72	Current Year Purchases	57,250	3,585	3,585		5-10	3,585	72
73	Fully Depreciated Assets	816,547					816,547	73
74								74
75	TOTALS	\$ 1,657,428	\$ 47,462	\$ 47,462	\$		\$ 1,417,520	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	N/A									77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Asset

	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)		\$ 7,497,598	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 355,589	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 412,152	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$ 56,563	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 5,075,249	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	N/A				87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93	N/A		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 1

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

	1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:			\$ <u>N/A</u>			3
4	Additions						4
5							5
6							6
7	TOTAL			\$			7

10. Effective dates of current rental agreement:
 Beginning _____
 Ending _____

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

	Fiscal Year Ending	Annual Rent
12.	<u>/2008</u>	\$ _____
13.	<u>/2009</u>	\$ _____
14.	<u>/2010</u>	\$ _____

8. List separately any amortization of lease expense included on page 4, line 34.
 This amount was calculated by dividing the total amount to be amortized
 by the length of the lease N/A N/A

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

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

15. Is Movable equipment rental included in building rental? YES NO
 16. Rental Amount for movable equipment: \$ 54,396 Description: Specialty Beds - \$24,104; Therapy Eqpt. - \$23,265; Copiers - \$5,549; Medical Eqpt. - \$1,478
 (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

* 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 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. <u>CLASSROOM PORTION:</u></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. <u>CLINICAL PORTION:</u></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			Total
		1	2	3	
		Drop-outs	Completed	Contract	
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wage (c)				
6	Transportation				
7	Contractual Payment:				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefit;
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefit;
- (c) For in-house training programs only. Do not include fringe benefit;
- (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

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	

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
1	Licensed Occupational Therapist	10A (1,2,3)	1671	hrs	\$ 60,567	12	\$ 710	\$ 1,345	1,683	\$ 62,622	1
2	Licensed Speech and Language Development Therapist	10A (1,2,3)	28	hrs	883	242	14,521		270	15,404	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10A (1,2,3)	4444	hrs	152,816	192	11,503	3,292	4,636	167,611	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				988,472		988,472	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				\$ 214,266	446	\$ 26,734	\$ 993,109	6,589	\$ 1,234,109	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed 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

Facility Name & ID Number St Francis Nursing & Rehab Center

0044370

Report Period Beginning: 07/01/2006

Ending:

06/30/2007

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/2007

(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	\$ 31,295	\$ 31,295	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 348,322)	961,387	961,387	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	9,450	9,450	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Exchange Account	336,140	336,140	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,338,272	\$ 1,338,272	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		188,421	13
14	Buildings, at Historical Cost	4,625,290	2,426,118	14
15	Leasehold Improvements, at Historical Cost	454,718	3,225,631	15
16	Equipment, at Historical Cost	2,232,630	1,657,428	16
17	Accumulated Depreciation (book methods)	(5,061,357)	(5,075,249)	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)	\$ 2,251,281	\$ 2,422,349	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,589,553	\$ 3,760,621	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 106,071	\$ 106,071	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 Facilities	9,443,643	9,443,643	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 9,549,714	\$ 9,549,714	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)	\$ 9,549,714	\$ 9,549,714	46
47	TOTAL EQUITY(page 18, line 24)	\$ (5,960,161)	\$ (5,789,093)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,589,553	\$ 3,760,621	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (4,855,929)	1
2	Restatements (describe):		2
3			3
4	Prior Period Adjustment	(58,095)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (4,914,024)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(1,046,137)	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)	\$ (1,046,137)	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)	\$ (5,960,161)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Francis Nursing & Rehab Center

0044370

Report Period Beginning: 07/01/2006

Ending: 06/30/2007

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 expenses.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 8,123,847	1
2	Discounts and Allowances for all Level	(3,378,497)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,745,350	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	987,063	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 987,063	8
C. Other Operating Revenue			
9	Payments for Educator		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	4,102	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,152,702	17
18	Sale of Supplies to Non-Patient		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	285,679	21
22	Laundry	34,138	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,476,621	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			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,209,034	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,288,259	31
32	Health Care	3,243,121	32
33	General Administrator	2,256,550	33
B. Capital Expense			
34	Ownership	409,985	34
C. Ancillary Expense			
35	Special Cost Centers	989,366	35
36	Provider Participation Fee	67,890	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,255,171	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,046,137)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,046,137)	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.

Facility Name & ID Number St Francis Nursing & Rehab Center

0044370

Report Period Beginning: 07/01/2006

Ending:

06/30/2007

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	1,720	2,183	\$ 85,375	\$ 39.11	1
2	Assistant Director of Nursing					2
3	Registered Nurses	27,852	32,214	1,106,820	34.36	3
4	Licensed Practical Nurses	9,514	10,943	278,589	25.46	4
5	CNAs & Orderlies	61,271	69,192	865,295	12.51	5
6	CNA Trainees					6
7	Licensed Therapist	5,771	6,143	214,266	34.88	7
8	Rehab/Therapy Aides	7,249	8,510	131,004	15.39	8
9	Activity Director					9
10	Activity Assistants	5,298	6,034	75,167	12.46	10
11	Social Service Worker	1,697	1,925	45,437	23.60	11
12	Dietician	116	116	2,318	19.98	12
13	Food Service Supervisor	3,721	4,285	82,316	19.21	13
14	Head Cook	7,427	8,111	106,979	13.19	14
15	Cook Helpers/Assistants	11,603	12,838	128,528	10.01	15
16	Dishwashers					16
17	Maintenance Worker	2,151	2,325	50,539	21.74	17
18	Housekeepers	12,615	13,977	136,251	9.75	18
19	Laundry	1,809	2,065	30,894	14.96	19
20	Administrator	1,839	2,136	108,367	50.73	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,856	9,812	166,629	16.98	24
25	Vocational Instructor					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 C: See Sch 20A	2,925	3,474	109,966	31.65	32
33	Other(specify) See Sch 20A	1,386	1,601	52,787	32.97	33
34	TOTAL (lines 1 - 33)	174,820	197,884	\$ 3,777,527 *	\$ 19.09	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	\$		35	
36	Medical Director	Monthly	27,528	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				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	\$	27,528		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	704	\$ 34,002	10(3)	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	704	\$ 34,002		53

SEE ACCOUNTANTS' COMPILATION REPORT

St. Francis Nursing & Rehabilitation Center
Provider # 0044370
07/01/06 - 06/30/07
Staffing & Salary Costs

Schedule 20A

Other Health Care Wages - Line 32:

	Hours <u>Worked</u>	Hours <u>Paid</u>	Salary or <u>Wages</u>	Ave. Hrly. <u>Wages</u>
MDS Care Plan Coordinator	2,829	3,298	107,711	32.66
Resident Care Counselor	96	176	2,255	12.81
TOTAL	<u>2,925</u>	<u>3,474</u>	<u>109,966</u>	<u>31.65</u>

Other Wages - Line 33:

	Hours <u>Worked</u>	Hours <u>Paid</u>	Salary or <u>Wages</u>	Ave. Hrly. <u>Wages</u>
Group Coordinator Spiritual Services	1,386	1,601	52,787	32.97
	<u>1,386</u>	<u>1,601</u>	<u>52,787</u>	<u>32.97</u>

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	
Michael Kaplan	Administrator	0	\$ 789	Workers' Compensation Insurance	\$ 46,264	IDPH License Fee	\$ 1,186	
Gary Mellman	Administrator	0	107,578	Unemployment Compensation Insurance	7,665	Advertising: Employee Recruitment		
				FICA Taxes	267,419	Health Care Worker Background Check		
				Employee Health Insurance	584,636	(Indicate # of checks performed 274)	4,378	
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Life Services Network	5,167	
				Group Life Insurance	14,402	Evanston City Collector	8,040	
				Group Disability Insurance	17,597	Miscellaneous Dues/Subscriptions	1,485	
				Group Dental Insurance	19,327			
				Employee Retirement	224,747			
				Employee Morale & Other Benefits	12,792	Less: Public Relations Expense	()	
				Allocated from Home Office	153,062	Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 108,367	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
				\$ 1,347,911		\$ 20,256		
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 Fees			\$ 478,051	N/A			Out-of-State Travel	\$
(Eliminated on Sch. V, Line 17, Col. 7)								
							In-State Travel	
							Seminar Expense	1,581
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 478,051	TOTAL		\$	(agree to Sch. V, line 24, col. 8)	
							\$ 1,581	
C. Professional Services								
Vendor/Payee	Type		Amount					
N/A								
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$					

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	8 Amount of Expense Amortized Per Year								
					5 FY2004	6 FY2005	7 FY2006	9 FY2007	10 FY2008	11 FY2009	12 FY2010	13 FY2011	13 FY2012
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2								N/A					
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union No
- (2) Are there any dues to nursing home associations included on the cost report Yes
If YES, give association name and amount Life Services Network - \$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? 7.5 yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expenses and the location of this expense on Sch. V. 10,406 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. 67,890
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 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? Yes
- (14) Is a portion of the building used for any function other than long term care services if the patient census listed on page 2, Section B No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount \$ 4,102
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation N/A
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 program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
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 is not yet complete.
- (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 services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees

SEE ACCOUNTANTS' COMPILATION REPORT

RECONCILIATION REPORT

St Francis Nursing & Re

12:06 PM 12/27/2007

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	151,297	equal to	151,297	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	8,295	equal to	8,295	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	0	equal to	0	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	N/A	equal to	0	#VALUE!	#VALUE!	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	412,152	equal to	412,152	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	54,396	equal to	54,396	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages	214,266	equal to	0	0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	245,637	equal to	376,641	-131,004	FAILED	Pg16 Z12+Z14.	N/A/B	1-4;40-43	8:2	Pg3 H20	N/A	10a	4
Special Serv.- Supplies	993,109	equal to	993,109	0	O.K.	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39.10a	2
Income Stat. General Serv.	1,288,259	equal to	1,288,259	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	3,243,121	equal to	3,243,121	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Administration	2,256,550	equal to	2,256,550	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	409,985	equal to	409,985	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	989,366	equal to	989,366	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+i	N/A	38to41+43	4
Income Stat. Prov. Partic.	67,890	equal to	67,890	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	2,336,079	equal to	2,446,045	-109,966	FAILED	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to	0	0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	214,266	equal to	0	0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	75,167	equal to	127,954	-52,787	FAILED	Pg20 K19+K20	A.	9-10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	45,437	equal to	45,437	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	320,141	equal to	320,141	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	50,539	equal to	50,539	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	136,251	equal to	136,251	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	30,894	equal to	30,894	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	108,367	equal to	108,367	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	166,629	equal to	166,629	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to	0	0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	3,777,527	equal to	3,777,527	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	0	< or = to	5,363	-5,363	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	27,528	< or = to	27,528	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	34,002	< or = to	53,463	-19,461	O.K.	Pg20 X14..X16+	B. & C.	17to39 and 50to6	2	Pg3 G19	N/A	10	3
Activity Consultant	0	< or = to	16,550	-16,550	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	0	< or = to	1,978	-1,978	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	108,367	equal to	108,367	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	478,051	equal to	478,051	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	794	equal to	#VALUE!	#VALUE!	Pg21 I41	C.	N/A	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	1,347,911	equal to	1,347,911	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	20,256	equal to	20,256	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	1,581	equal to	1,581	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	67,890	equal to	67,890	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	0	< or = to	153,062	-153,062	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	0	equal to	0	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to	0	0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	9,013	equal to	9,013	0	O.K.	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	156,793	equal to	156,793	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6l Y4	B.	14	8
Total loan balance	0	equal to	0	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27.	N/A	29+39-41	2
Real estate tax accrual	0	equal to	0	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	188,421	equal to	188,421	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	5,651,749	equal to	5,651,749	0	O.K.	Pg12 to 12l L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	1,657,428	equal to	1,657,428	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	5,075,249	equal to	5,075,249	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	-5,960,161	equal to	-5,960,161	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	-1,046,137	equal to	-1,046,137	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to	0	0	O.K.	Pg22 F31-J31..1	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	3,589,553	equal to	3,589,553	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1

Capital Rate Data

YOU MUST CHECK THE CAPITAL GAIN THAT IS LIMITED TO THE COST BASIS

Table with columns for Facility Name, Location, and various tax-related fields like Capital Rate, etc.

CAPITAL CALCULATION

A. Determine the base year for your building from Table A

Table with columns for Year, Value, and other calculation parameters.

Calculation

1. Work Table A Line 10, Column (B)

Table with columns for Line, Value, and other calculation parameters.

WORK TABLE A

Year Adjusted Columns

Table with columns for Year, Adjusted, Columns, and other calculation parameters.

TABLE 1

Table 1 - 1983 Building Year

Table with columns for Year, Value, and other calculation parameters.

TABLE 2

Table 2 - 1983 Building Year

Table with columns for Year, Value, and other calculation parameters.

TABLE 3

Table 3 - 1983 Building Year

Table with columns for Year, Value, and other calculation parameters.

TABLE 4

Table 4 - 1983 Building Year

Table with columns for Year, Value, and other calculation parameters.

TABLE 5

Table 5 - 1983 Building Year

Table with columns for Year, Value, and other calculation parameters.

TABLE 6

Table 6 - 1983 Building Year

Table with columns for Year, Value, and other calculation parameters.

TABLE 7

Table 7 - 1983 Building Year

Table with columns for Year, Value, and other calculation parameters.

TABLE 8

Table 8 - 1983 Building Year

Table with columns for Year, Value, and other calculation parameters.

IF REVENUE

Test whether building is continuously owned

	Salaries	Supplies	Other	Total	Reclass- ifications	Reclassified Total	Adjusted Adjustments	Adjusted Total
1. Dietary	320,141	33,746	5,363	359,250	0	359,250	0	359,250
2. Food Purchase	0	230,447	0	230,447	0	230,447	-4,102	226,345
3. Housekeeping	136,251	26,751	4,778	167,780	0	167,780	0	167,780
4. Laundry	30,894	211,439	0	242,333	0	242,333	0	242,333
5. Heat and Other Utilities	0	0	129,039	129,039	0	129,039	0	129,039
6. Maintenance	50,539	12,340	96,531	159,410	0	159,410	0	159,410
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	537,825	514,723	235,711	1,288,259	0	1,288,259	-4,102	1,284,157
9. Medical Director	0	0	27,528	27,528	0	27,528	0	27,528
10. Nursing & Medical Records	2,446,045	133,788	53,463	2,633,296	0	2,633,296	0	2,633,296
10a. Therapy	345,270	4,637	26,734	376,641	0	376,641	0	376,641
11. Activities	127,954	13,539	16,550	158,043	0	158,043	0	158,043
12. Social Services	45,437	198	1,978	47,613	0	47,613	0	47,613
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	2,964,706	152,162	126,253	3,243,121	0	3,243,121	0	3,243,121
17. Administrative	108,367	0	478,051	586,418	0	586,418	-478,051	108,367
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	794	794	0	794	0	794
20. Fees, Subscriptions & Promotion	0	0	20,256	20,256	0	20,256	0	20,256
21. Clerical & General Office	166,629	28,392	7,422	202,443	0	202,443	416,955	619,398
22. Employee Benefits & Payroll	0	0	1,194,849	1,194,849	0	1,194,849	153,062	1,347,911
23. Inservice Training & Education	0	0	0	0	0	0	0	0
24. Travel and Seminar	0	0	2,112	2,112	0	2,112	-531	1,581
25. Other Admin. Staff Trans	0	0	35,676	35,676	0	35,676	0	35,676
26. Insurance-Prop.Liab.Malpractice	0	0	214,002	214,002	0	214,002	0	214,002
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	274,996	28,392	1,953,162	2,256,550	0	2,256,550	91,435	2,347,985
29. Total General Administrative	3,777,527	695,277	2,315,126	6,787,930	0	6,787,930	87,333	6,875,263
30. Depreciation	0	0	355,589	355,589	0	355,589	56,563	412,152
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	0	0	0	0	8,295	8,295
33. Real Estate	0	0	0	0	0	0	0	0
34. Rent - Facility & Grounds	0	0	0	0	0	0	0	0
35. Rent - Equipment & Vehicles	0	0	54,396	54,396	0	54,396	0	54,396
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	409,985	409,985	0	409,985	64,858	474,843
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	988,472	0	988,472	0	988,472	0	988,472
40. Barber and Beauty Shop	0	0	0	0	0	0	0	0
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42	0	0	67,890	67,890	0	67,890	0	67,890
43. Other (specify):*	0	0	894	894	0	894	-894	0
44. Total Special Cost Ce	0	988,472	68,784	1,057,256	0	1,057,256	-894	1,056,362
45. Grand Total	3,777,527	1,683,749	2,793,895	8,255,171	0	8,255,171	151,297	8,406,468

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	31,295	31,295
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	961,387	961,387
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	0	0
7. Other Prepaid Expenses	9,450	9,450
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	336,140	336,140
10. Total current assets	1,338,272	1,338,272
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	0	188,421
14. Buildings, at Historical Cost	4,625,290	2,426,118
15. Leasehold Improvements, Historical Cost	454,718	3,225,631
16. Equipment, at Historical Cost	2,232,630	1,657,428
17. Accumulated Depreciation (book methods)	-5,061,357	-5,075,249
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	0	0
24. Total Long-Term Assets	2,251,281	2,422,349
25. Total Assets	3,589,553	3,760,621
CURRENT LIABILITIES		
26. Accounts Payable	106,071	106,071
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	0	0
31. Accrued Taxes Payable	0	0
32. Accrued Real Estate Taxes	0	0
33. Accrued Interest Payable	0	0
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	9,443,643	9,443,643
37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	9,549,714	9,549,714
LONG TERM LIABILITES		
39. Long-Term Notes Payable	0	0
40. Mortgage Payable	0	0
41. Bonds Payable	0	0
42. Deferred Compensation	0	0
43. Other Long-Term Liabilities (specify):	0	0
44. Other Long-Term Liabilities (specify):	0	0
45. Total Long-Term Liabilities	0	0
46. Total Liabilities	9,549,714	9,549,714
47. Total Equity	-5,960,161	-5,789,093
48. Total Liabilities and Equity	3,589,553	3,760,621

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	8,123,847
2. Discounts and Allowances for all Levels	-3,378,497
Subtotal - Inpatient Care	4,745,350
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	987,063
7. Oxygen	0
Subtotal - Ancillary Revenue	987,063
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	4,102
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	1,152,702
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiology and X-Ray	0
21. Other Medical Services	285,679
22. Laundry	34,138
Subtotal - Other Operating Revenue	1,476,621
24. Contributions	0
25. Interest and Other Investments Income	0
Subtotal - Non-Operating Revenue	-
27. Other Revenue (specify):	0
28. Other Revenue (specify):	0
Subtotal - Other Revenue	-
30. Total Revenue	7,209,034
31. General Services	1,288,259
32. Health Care	3,243,121
33. General Administration	2,256,550
34. Ownership	409,985
35. Special Cost Centers	989,366
35. Provider Participation Fee	67,890
37. Other	0
40. Total Expenses	8,255,171
41. Income Before Income Taxes	-1,046,137
42. Income Taxes	0
43. Net Income or Loss for the Year	-1,046,137

St Francis Nursing & Rehab Center
 IDPA Comparative Data - Per Resident Day Cost
 Year Ending

Cost Report Line	Description	Your Facility	2006 Average Median Cost Per Day	
			State	HSA
1	Dietary	9.75	-	#N/A
2	Food Purchase	6.14	-	#N/A
3	Housekeeping	4.55	-	#N/A
4	Laundry	6.58	-	#N/A
5	Heat & Other Utilities	3.50	-	#N/A
6	Maintenance	4.33	-	#N/A
8	Total General Services	34.85	-	#N/A
10	Nursing & Medical Records	71.46	-	#N/A
10A	Therapy	10.22	-	#N/A
11	Activities	4.29	-	#N/A
12	Social Services	1.29	-	#N/A
16	Total Health Care & Programs	88.01	-	#N/A
17	Administration	2.94	-	#N/A
19	Professional Services	0.02	-	#N/A
21	Clerical & Gen. Office Expense	16.81	-	#N/A
22	Employee Benefits & PR Taxes	36.58	-	#N/A
24	Travel & Seminar	0.04	-	#N/A
26	Insurance-Property, Liability & Malpractice	5.81	-	#N/A
28	Total General Administrative	63.72	-	#N/A
29	Total Operating Expenses	186.57	-	#N/A
30	Depreciation	11.18	-	#N/A
32	Interest	0.23	-	#N/A
33	Real Estate Taxes	-	-	#N/A
37	Total Ownership	12.89	-	#N/A
	Total Operating and Ownership Cost	199.45	-	#N/A

Notes:
 Your Facility data is from page 3, column 8 of your 2007 Medicaid cost report, divided by your annual census.

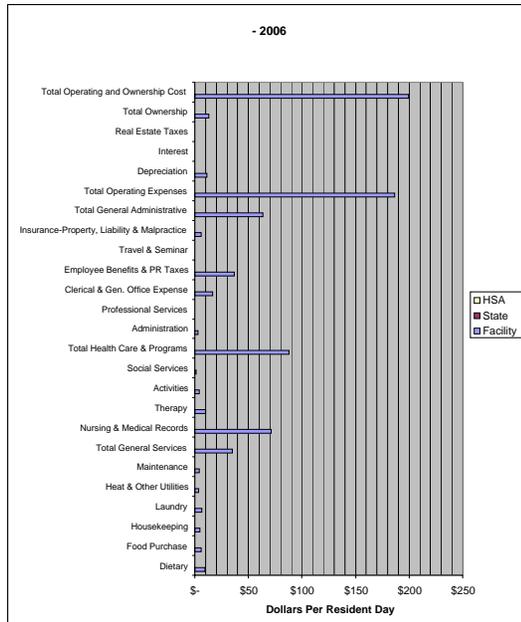
The Average Median Cost Per Day for the State and your HSA is taken from the most recent data available from the Illinois Department of Health Care and Family Services and corresponds with the respective cost report data after final adjustments.

Enter your HSA # in next column =====
 Census (Pulls from Page 2) 36,851

IDPA LTC Profiles
 LTC Median Per Diem Cost by HSA - 2005 Cost Reports
 2005 (Run August 15, 2006)

UN-INFLATED

Cost Report Line	Description	State-Wide	HSA											10th %	90th %	
			1	2	3	4	5	6	7	8	9	10	11			
1	Dietary															
2	Food Purchase															
3	Housekeeping															
4	Laundry															
5	Heat & Other Utilities															
6	Maintenance															
8	TOTAL GENERAL SERVICES															
10	Nursing & Medical Records															
10A	Therapy															
11	Activities															
12	Social Services															
16	TOTAL HEALTH CARE & PROGRAMS															
17	Administration															
19	Professional Services															
21	Clerical & Gen. Office Expense															
22	Employee Benefits & PR Taxes															
24	Travel & Seminar															
26	Insurance-Property, liability & Malpractice															
28	TOTAL GENERAL ADMINISTRATIVE															
29	TOTAL OPERATING EXPENSES															
30	Depreciation															
32	Interest															
33	Real Estate Taxes															
37	TOTAL OWNERSHIP															
	TOTAL OPERATING & OWNERSHIP COST															



St Francis Nursing & Rehab Center
 HSA Comparative Rate - Per Resident Day Cost
 Year Ending

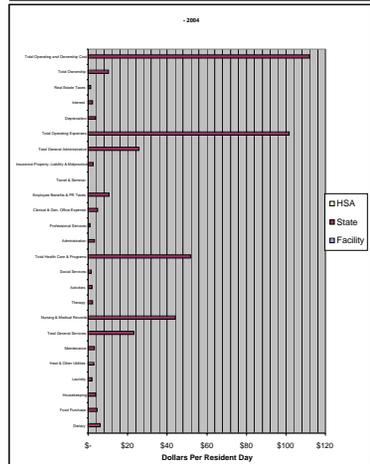
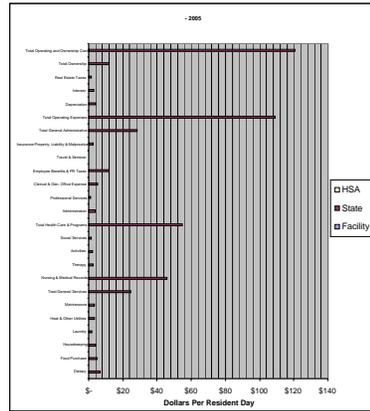
Enter your HSA # in row column
 Column (P)H from Page 2

05/27/20

Cost Report Line	Description	2007		2008 Median		2009		2008 Median		2005		2005 Median	
		Per Diem	Cost Per Day	Per Diem	Cost Per Day	Per Diem	Cost Per Day	Per Diem	Cost Per Day	Per Diem	Cost Per Day	Per Diem	Cost Per Day
1	Dietary	6,767,178	6.52	ANA	PFALLER	6.52	ANA	HEVVO	6.23	ANA			
2	Food Purchase	4,124,071	4.68	ANA	PFALLER	4.68	ANA	HEVVO	4.53	ANA			
3	Housekeeping	4,570,994	4.02	ANA	PFALLER	4.02	ANA	HEVVO	3.77	ANA			
4	Laundry	6,570,024	1.96	ANA	PFALLER	1.96	ANA	HEVVO	1.86	ANA			
5	House & Office Utilities	3,934,417	3.31	ANA	PFALLER	3.31	ANA	HEVVO	3.02	ANA			
6	Maintenance	4,325,985	3.51	ANA	PFALLER	3.51	ANA	HEVVO	3.21	ANA			
8	Total General Services	34,877,727	24.43	ANA	PFALLER	24.43	ANA	HEVVO	23.12	ANA			
10	Nursing & Medical Supplies	71,477,925	63.97	ANA	PFALLER	63.97	ANA	HEVVO	64.68	ANA			
10A	Therapy	10,220,645	2.45	ANA	PFALLER	2.45	ANA	HEVVO	2.16	ANA			
11	Activities	4,260,922	2.06	ANA	PFALLER	2.06	ANA	HEVVO	1.95	ANA			
12	Social Services	1,202,849	1.58	ANA	PFALLER	1.58	ANA	HEVVO	1.48	ANA			
16	Total Health Care & Programs	10,182,521	16.45	ANA	PFALLER	16.45	ANA	HEVVO	15.90	ANA			
17	Administration	2,938,808	3.90	ANA	PFALLER	3.90	ANA	HEVVO	3.24	ANA			
19	Professional Services	10,123,542	1.61	ANA	PFALLER	1.61	ANA	HEVVO	1.67	ANA			
21	Chemical & Gas, Office Equipment	16,488,171	3.65	ANA	PFALLER	3.65	ANA	HEVVO	4.89	ANA			
22	Employee Benefits & HR Taxes	36,577,725	11.77	ANA	PFALLER	11.77	ANA	HEVVO	10.66	ANA			
24	Tax & Seminar	0,029,025	0.09	ANA	PFALLER	0.09	ANA	HEVVO	0.09	ANA			
26	Insurance (Property, Liability & Malpractice)	5,897,227	2.69	ANA	PFALLER	2.69	ANA	HEVVO	2.67	ANA			
28	Total General Administration	63,716,509	28.30	ANA	PFALLER	28.30	ANA	HEVVO	25.82	ANA			
29	Total Operating Expenses	106,460,624	100.93	ANA	PFALLER	100.93	ANA	HEVVO	100.50	ANA			
30	Depreciation	11,184,283	3.95	ANA	PFALLER	3.95	ANA	HEVVO	3.78	ANA			
32	Interest	10,220,007	2.87	ANA	PFALLER	2.87	ANA	HEVVO	2.22	ANA			
33	Rent State Taxes	0	1.51	ANA	PFALLER	1.51	ANA	HEVVO	1.48	ANA			
37	Total Overhead	12,804,485	11.75	ANA	PFALLER	11.75	ANA	HEVVO	10.42	ANA			
	Total Operating and Overhead Cost	119,465,109	112.68	ANA	PFALLER	112.68	ANA	HEVVO	112.04	ANA			

Your facility data is from page 1, column K of each of your respective Medicaid cost reports, divided by the respective annual census.

The 2005, 2006, 2007, 2008 State Data Facility, for the State and your HSA is taken from data available from the Illinois Department of Health Care and Family Services and corresponds with the respective cost report data after final adjustments.



IDPA LTC Profiles
 LTC Median Per Diem Cost by HSA - 2006 Cost Reports
 2006

UN-INFLATED

Cost Report Line	Description
1	Dietary
2	Food Purchase
3	Housekeeping
4	Laundry
5	Heat & Other Utilities
6	Maintenance
8	TOTAL GENERAL SERVICES
10	Nursing & Medical Records
10A	Therapy
11	Activities
12	Social Services
16	TOTAL HEALTH CARE & PROGRAMS
17	Administration
19	Professional Services
21	Clerical & Gen. Office Expense
22	Employee Benefits & PR Taxes
24	Travel & Seminar
26	Insurance-Property, liability & Malpractice
28	TOTAL GENERAL ADMINISTRATIVE
29	TOTAL OPERATING EXPENSES
30	Depreciation
32	Interest
33	Real Estate Taxes
37	TOTAL OWNERSHIP
	TOTAL OPERATING & OWNERSHIP COST

State-Wide	HSA											
	1	2	3	4	5	6	7	8	9	10	11	

10th % 90th %

2006 Costs

2006 Census

Cost Report Line	Description
1	Dietary
2	Food Purchase
3	Housekeeping
4	Laundry
5	Heat & Other Utilities
6	Maintenance
8	TOTAL GENERAL SERVICES
10	Nursing & Medical Records
10A	Therapy
11	Activities
12	Social Services
16	TOTAL HEALTH CARE & PROGRAMS
17	Administration
19	Professional Services
21	Clerical & Gen. Office Expense
22	Employee Benefits & PR Taxes
24	Travel & Seminar
26	Insurance-Property, liability & Malpractice
28	TOTAL GENERAL ADMINISTRATIVE
29	TOTAL OPERATING EXPENSES
30	Depreciation
32	Interest
33	Real Estate Taxes
37	TOTAL OWNERSHIP
	TOTAL OPERATING & OWNERSHIP COST

2006 - Average Wage Data Table

Total staff hours including contract nursing per diem
 Nursing hours including contract nurses per diem
 RN
 LPN
 CNA
 DON
 ADON

State-Wide	HSA										
	1	2	3	4	5	6	7	8	9	10	11

2006 - Staffing and Occupancy Data

Average Occupancy
 Medicaid Utilization
 Medicare Utilization

State-Wide	HSA										
	1	2	3	4	5	6	7	8	9	10	11

IDPA LTC Profiles
 LTC Median Per Diem Cost by HSA - 2004 Cost Reports
 2004 (Run June 1, 2004)

UN-INFLATED

Cost Report	Description	State-Wide	HSA 1	HSA 2	HSA 3	HSA 4	HSA 5	HSA 6	HSA 7	HSA 8	HSA 9	HSA 10	HSA 11	10th %	90th %
1	Dietary	6.23	7.09	6.81	5.63	6.81	5.56	6.37	6.37	6.37	6.12	7.09	5.94	4.27	10.11
2	Food Purchase	4.53	4.79	4.73	4.56	4.73	4.33	4.48	4.48	4.48	4.40	4.79	4.27	3.48	6.23
3	Housekeeping	3.77	3.68	3.76	3.10	3.76	3.37	4.12	4.12	4.12	3.93	3.68	3.66	2.59	5.78
4	Laundry	1.86	2.27	1.99	1.79	1.99	1.97	1.64	1.64	1.64	1.62	2.27	2.16	1.00	3.16
5	Heat & Other Utilities	3.02	3.13	3.07	3.04	3.07	2.71	3.06	3.06	3.06	2.87	3.13	2.86	2.10	4.39
6	Maintenance	3.21	3.63	3.33	3.22	3.33	2.45	3.35	3.35	3.35	3.25	3.63	2.88	2.02	5.28
8	TOTAL GENERAL SERVICES	23.12	25.66	23.97	21.71	23.97	21.28	23.50	23.50	23.50	23.47	25.66	21.76	18.27	32.52
10	Nursing & Medical Records	44.05	43.48	45.03	40.84	45.03	35.79	47.50	47.50	47.50	47.81	43.48	44.17	28.00	68.18
10A	Therapy	2.16	2.01	3.55	4.52	3.55	2.05	1.47	1.47	1.47	2.21	2.01	3.40	-	12.21
11	Activities	1.95	2.28	1.95	1.58	1.95	1.34	2.21	2.21	2.21	2.16	2.28	1.54	1.07	3.52
12	Social Services	1.48	1.44	1.63	1.10	1.63	1.27	1.64	1.64	1.64	1.34	1.44	1.37	0.62	3.10
16	TOTAL HEALTH CARE & PROGRAMS	51.90	52.55	53.10	49.97	53.10	43.69	53.78	53.78	53.78	56.90	52.55	53.31	33.59	81.45
17	Administration	3.24	3.47	3.24	3.08	3.24	3.65	3.19	3.19	3.19	3.24	3.47	2.99	1.75	8.15
19	Professional Services	0.97	1.19	0.70	0.68	0.70	0.77	1.09	1.09	1.09	1.34	1.19	0.70	0.05	2.58
21	Clerical & Gen. Office Expense	4.89	4.21	5.22	4.23	5.22	4.03	5.31	5.31	5.31	5.13	4.21	4.41	2.35	10.74
22	Employee Benefits & PR Taxes	10.66	10.98	12.14	9.56	12.14	8.62	11.17	11.17	11.17	11.21	10.98	9.81	6.89	20.31
24	Travel & Seminar	0.09	0.12	0.10	0.09	0.10	0.15	0.08	0.08	0.08	0.04	0.12	0.09	-	0.34
26	Insurance-Property, liability & Malpractice	2.67	2.38	2.53	2.36	2.53	2.33	3.03	3.03	3.03	2.47	2.38	2.16	0.85	4.36
28	TOTAL GENERAL ADMINISTRATIVE	25.82	26.66	27.48	23.91	27.48	22.08	26.27	26.27	26.27	27.23	26.66	22.86	17.40	40.90
29	TOTAL OPERATING EXPENSES	101.59	104.24	105.69	96.02	105.69	89.62	103.51	103.51	103.51	106.84	104.24	100.77	71.40	151.58
30	Depreciation	3.74	3.67	3.95	3.52	3.95	2.64	4.23	4.23	4.23	3.72	3.67	3.20	1.00	8.58
32	Interest	2.22	2.43	1.42	1.72	1.42	0.55	3.91	3.91	3.91	2.22	2.43	0.94	-	10.11
33	Real Estate Taxes	1.40	1.04	1.00	0.84	1.00	0.87	3.21	3.21	3.21	1.30	1.04	1.14	-	5.54
37	TOTAL OWNERSHIP	10.42	8.95	9.03	7.51	9.03	6.11	14.54	14.54	14.54	10.03	8.95	9.17	3.61	22.83
	TOTAL OPERATING & OWNERSHIP COST	112.01	113.19	114.72	103.53	114.72	95.73	118.05	118.05	118.05	116.87	113.19	109.94	75.01	174.41

Cost Report	Description	2004 Costs	2004 Census
1	Dietary	3.48	6.23
2	Food Purchase	2.59	5.78
3	Housekeeping	1.00	3.16
4	Laundry	2.10	4.39
5	Heat & Other Utilities	2.02	5.28
6	Maintenance	28.00	68.18
8	TOTAL GENERAL SERVICES	18.27	32.52
10	Nursing & Medical Records	-	12.21
10A	Therapy	1.07	3.52
11	Activities	0.62	3.10
12	Social Services	-	-
16	TOTAL HEALTH CARE & PROGRAMS	33.59	81.45
17	Administration	1.75	8.15
19	Professional Services	0.05	2.58
21	Clerical & Gen. Office Expense	2.35	10.74
22	Employee Benefits & PR Taxes	6.89	20.31
24	Travel & Seminar	-	0.34
26	Insurance-Property, liability & Malpractice	0.85	4.36
28	TOTAL GENERAL ADMINISTRATIVE	17.40	40.90
29	TOTAL OPERATING EXPENSES	71.40	151.58
30	Depreciation	1.00	8.58
32	Interest	-	10.11
33	Real Estate Taxes	-	5.54
37	TOTAL OWNERSHIP	3.61	22.83
	TOTAL OPERATING & OWNERSHIP COST	75.01	174.41

Average Wage Data Table

State-Wide	HSA 1	HSA 2	HSA 3	HSA 4	HSA 5	HSA 6	HSA 7	HSA 8	HSA 9	HSA 10	HSA 11
Total staff hours including contract nurses per diem	5.00	5.30	5.30	5.30	5.10	4.80	4.80	4.80	5.10	5.30	5.20
Nursing hours including contract nurses per diem	3.00	3.20	3.20	3.30	3.10	2.80	2.80	2.80	3.10	3.20	3.10
RN	22.54	22.05	20.73	19.72	20.73	17.47	25.72	25.72	25.72	23.44	20.42
LPN	18.4	18.02	17.23	15.4	17.23	13.82	21.06	21.06	21.06	19.09	17.13
CNA	10.02	10.13	10.03	9.32	10.03	8.4	10.52	10.52	10.52	10.13	9.84
DON	28.97	27.38	25.17	23.86	25.17	22.23	34.39	34.39	34.39	30.41	25.97
ADON	25.23	23.95	21.85	19.41	21.85	19.13	28.74	28.74	28.74	26.68	23.77

2003 - Staffing and Occupancy Data

State-Wide	HSA 1	HSA 2	HSA 3	HSA 4	HSA 5	HSA 6	HSA 7	HSA 8	HSA 9	HSA 10	HSA 11	
Average Occupancy	80.50%	80.70%	80.40%	78.10%	80.40%	74.40%	81.80%	81.80%	81.80%	82.90%	80.70%	78.20%
Medicaid Utilization	65.00%	57.00%	56.70%	58.50%	56.70%	61.80%	70.60%	70.60%	70.60%	64.50%	57.00%	60.60%
Medicare Utilization	9.40%	7.70%	8.90%	9.30%	8.90%	8.80%	9.90%	9.90%	9.90%	10.30%	7.70%	8.90%