



Facility Name & ID Number Brother James Court

# 0020495 Report Period Beginning: 07/01/07 Ending: 06/30/08

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	<u>99</u>	Intermediate/DD	<u>99</u>	<u>36,234</u>	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>99</u>	TOTALS	<u>99</u>	<u>36,234</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment			
		Medicaid Recipient	Private Pay	Other	
8	SNF				8
9	SNF/PED				9
10	ICF				10
11	ICF/DD	<u>33,250</u>	<u>366</u>	<u>366</u>	<u>33,982</u>
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	<u>33,250</u>	<u>366</u>	<u>366</u>	<u>33,982</u>

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.78%

D. How many bed-hold days during this year were paid by the Department?

1,488 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES  NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES  NO

I. On what date did you start providing long term care at this location?

Date started 10/01/1975

J. Was the facility purchased or leased after January 1, 1978?

YES  Date \_\_\_\_\_ NO

K. Was the facility certified for Medicare during the reporting year?

YES  NO  If YES, enter number of beds certified \_\_\_\_\_ and days of care provided \_\_\_\_\_

Medicare Intermediary \_\_\_\_\_

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

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

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

Facility Name & ID Number Brother James Court # 0020495 Report Period Beginning: 07/01/07 Ending: 06/30/08

**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
	<b>A. General Services</b>										
1	Dietary	223,010	18,660	3,561	245,231		245,231	245,231			1
2	Food Purchase		162,614		162,614		162,614	162,614			2
3	Housekeeping	53,304	17,951		71,255		71,255	71,255			3
4	Laundry	58,165	7,925		66,090		66,090	66,090			4
5	Heat and Other Utilities			177,019	177,019		177,019	177,019			5
6	Maintenance	56,407	197	58,541	115,145		115,145	115,145			6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	<b>390,886</b>	<b>207,347</b>	<b>239,121</b>	<b>837,354</b>		<b>837,354</b>	<b>837,354</b>			<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			2,000	2,000		2,000	2,000			9
10	Nursing and Medical Records	1,475,114	38,754	1,200	1,515,068		1,515,068	1,515,068			10
10a	Therapy	22,894	386	20,032	43,312		43,312	43,312			10a
11	Activities	23,526	4,389	7,746	35,661		35,661	35,661			11
12	Social Services	151,359	443	6,000	157,802		157,802	157,802			12
13	CNA Training										13
14	Program Transportation			13,645	13,645		13,645	13,645			14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>1,672,893</b>	<b>43,972</b>	<b>50,623</b>	<b>1,767,488</b>		<b>1,767,488</b>	<b>1,767,488</b>			<b>16</b>
	<b>C. General Administration</b>										
17	Administrative			79,606	79,606		79,606	79,606			17
18	Directors Fees										18
19	Professional Services			102,091	102,091		102,091	102,091			19
20	Dues, Fees, Subscriptions & Promotions			8,113	8,113		8,113	8,113			20
21	Clerical & General Office Expenses	204,612	12,538	115,364	332,514		332,514	(61,648)	270,866		21
22	Employee Benefits & Payroll Taxes			496,873	496,873		496,873	496,873			22
23	Inservice Training & Education										23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			52,546	52,546		52,546	52,546			26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	<b>204,612</b>	<b>12,538</b>	<b>854,593</b>	<b>1,071,743</b>		<b>1,071,743</b>	<b>(61,648)</b>	<b>1,010,095</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>2,268,391</b>	<b>263,857</b>	<b>1,144,337</b>	<b>3,676,585</b>		<b>3,676,585</b>	<b>(61,648)</b>	<b>3,614,937</b>		<b>29</b>

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

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

Facility Name & ID Number Brother James Court #0020495 Report Period Beginning: 07/01/07 Ending: 06/30/08

## 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	
	<b>D. Ownership</b>											
30	Depreciation			124,800	124,800		124,800	106,292	231,092			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			270,000	270,000		270,000	(270,000)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			394,800	394,800		394,800	(163,708)	231,092			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			232,342	232,342		232,342		232,342			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			232,342	232,342		232,342		232,342			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,268,391	263,857	1,771,479	4,303,727		4,303,727	(225,356)	4,078,371			45

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

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

# **0020495**

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

Ending: **06/30/08**

**VI. ADJUSTMENT DETAIL**

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(719)	21,3		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(60,929)	21,1		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (61,648)		\$	30

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(163,708)	34,30	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (163,708)		36
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ (225,356)		37

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

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

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

BHF USE ONLY					
48		49		50	51
					52

Brother James Court

ID# 0020495

Report Period Beginning: 07/01/07

Ending: 06/30/08

Sch. V Line Reference

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	<b>Total</b>	0	49



STATE OF ILLINOIS

Facility Name & ID Number Brother James Court

# 0020495

Report Period Beginning:

07/01/07

Ending:

Summary B

06/30/08

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	106,292	0	0	0	0	0	0	0	0	0	106,292	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(270,000)	0	0	0	0	0	0	0	0	0	(270,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>0</b>	<b>(163,708)</b>	<b>0</b>	<b>(163,708)</b>	<b>37</b>								
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>0</b>	<b>(163,708)</b>	<b>0</b>	<b>(163,708)</b>	<b>45</b>								

Facility Name & ID Number Brother James Court

# 0020495

Report Period Beginning:

07/01/07

Ending:

06/30/08

**VII. RELATED PARTIES**

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
N/A	N/A	N/A	None	Francixan Brothers of The Holy Cross	Springfield	Religious Order
				Springfield Development Center	Springfield	Day Training Prog.
				Weber Care Corp	Springfield	Community Living Facility

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: 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	34 Facility Rent	\$ 270,000	Franciscan Brothers of the Holy Cross	100.00%	\$	(270,000)	1
2	V	30 Depreciation		Franciscan Brothers of the Holy Cross	100.00%	106,292	106,292	2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 270,000			\$ 106,292	\$ * (163,708)	14

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

Facility Name & ID Number Brother James Court # 0020495 Report Period Beginning: 07/01/07 Ending: 06/30/08

## VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Bro. Gerald Voycheck	Staff Trainer		None	None	Various	30.00	Consultant	\$ 4,675	21,3	1
2											2
3	Bro. Anthony Joseph McCoy	Mission Effectiveness		None	None	20	50.00	Consultant	17,520	21,3	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 22,195		13

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

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

Facility Name & ID Number Brother James Court

# 0020495

Report Period Beginning: 07/01/07

Ending: 06/30/08

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

**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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1										1										
2										2										
3										3										
4										4										
5										5										
<b>Working Capital</b>																				
6										6										
7										7										
8										8										
9	<b>TOTAL Facility Related</b>					\$	\$		\$	9										
<b>B. Non-Facility Related*</b>																				
10										10										
11										11										
12										12										
13										13										
14	<b>TOTAL Non-Facility Related</b>					\$	\$		\$	14										
15	<b>TOTALS (line 9+line14)</b>					\$	\$		\$	15										

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

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

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



**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

**2007 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Brother James Court COUNTY Sangamon

FACILITY IDPH LICENSE NUMBER 0020495

CONTACT PERSON REGARDING THIS REPORT \_\_\_\_\_

TELEPHONE (\_\_\_\_) \_\_\_\_\_ FAX #: (\_\_\_\_) \_\_\_\_\_

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2007 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 2007.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ _____	\$ _____

**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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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

Facility Name & ID Number Brother James Court

# 0020495 Report Period Beginning:

07/01/07 Ending:

06/30/08

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 47,210 B. General Construction Type: Exterior Brick/Stone Frame Steel Number of Stories 1

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's 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).

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

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

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	3

Facility Name &amp; ID Number Brother James Court

# 0020495

Report Period Beginning:

07/01/07

Ending:

06/30/08

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1975	1975	\$ 1,003,250	\$	30	\$	\$	\$ 1,003,250	4
5			1996	1996	1,251,493		30	41,716	41,716	479,739	5
6			1997	1997	1,256,490		30	41,883	41,883	423,479	6
7											7
8											8
		<b>Improvement Type**</b>									
9		NEW WING-HEATING AND AIR CONDITIONING		1997	18,883		30	629	629	6,661	9
10		REPAVE PARKING LOT		1986	42,236		10			42,236	10
11		PAINTING/DECORATING		1979	2,591		5			2,591	11
12		BJC-BLDG IMPROVEMENTS		1980	16,233		11			16,233	12
13		BJC-BLDG IMPROVEMENTS		1984	21,419		10			21,419	13
14		BJC-REMODELING		1987	69,555		10			69,555	14
15		BJC-WATER LINE		1987	14,120		20	706	706	13,767	15
16		INSULATION		1991	9,175		15			9,175	16
17		ELECTRICAL REPAIR		1991	613		10			613	17
18		BOILER TANK REMOVAL		1992	15,089		20	754	754	11,854	18
19		TANK ROVEAL		1992	8,500		10			8,500	19
20		DISHWASHING ROOM SEWER		1992	10,680		20	534	534	8,544	20
21		BJC-STEAM LINE		1985	14,479		10			14,479	21
22		BJC-BLDG IMPROVEMENTS		1975	19,600		24			19,600	22
23		BJC-DINING AREA REMODELING		1976	34,951		10			34,951	23
24		BJC-SIDEWALK/PATIO		1976	3,545		10			3,545	24
25		BJC-BIKE RINK		1978	2,500		50			2,500	25
26		BJC-AIR CONDITIONING SYSTEM		1979	22,876		10			22,876	26
27		BJC-SITE IMPROVEMENT		1979	1,440		26			1,440	27
28		ROOF		1979	12,166		10			12,166	28
29		ROOFING		1986	45,811		10			45,811	29
30		REMODELING		1988	46,656		10			46,656	30
31		WATER LINE		1989	3,166		20	158	158	3,008	31
32		SEWAGE TREATMENT PLANT		1990	6,411		20	321	321	5,663	32
33		TANK ROVEAL		1991	9,809		10			9,809	33
34		PARKING LOT		1992	10,452		10			10,452	34
35		PAINT RESTROOMS		1992	230		5			230	35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name &amp; ID Number Brother James Court

# 0020495

Report Period Beginning:

07/01/07

Ending:

06/30/08

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	BOILER ROOM REMODELING	1993	\$ 15,106	\$	20	\$ 755	\$ 755	\$ 10,958	37
38	REPAVE PARKING LOT	1994	850		10			850	38
39	PUMP	1994	734		10			734	39
40	AIRCONDITIONER WORK	1994	943		10			943	40
41	BOILER ROOM PROJECT	1994	170,330		20	8,517	8,517	113,763	41
42	LAND IMPROVEMENT - TREES	1996	3,470		20	174	174	1,966	42
43	BIC-BLDG IMPROVEMENTS	1998	15,712		30	524	524	10,562	43
44	WATER LINE REPAIR	1999	3,102		10	310	310	2,559	44
45	LAND IMPROVEMENT - TREES	1999	25,849		20	1,292	1,292	10,770	45
46	GATE	1999	550		5			550	46
47	REMODELING	1999	5,773		10	577	577	4,667	47
48	FLOOR	2000	1,683		7	80	80	1,683	48
49	TOTAL LIFE CENTER	1998	122,261		30	4,075	4,075	39,056	49
50	PARKIGLOTBLACKTOP	2000	49,310		15	3,287	3,287	25,476	50
51	LEASEHOLD IMPROVEMENTS	1985	15,200		10			15,200	51
52	LEASEHOLD IMPROVEMENTS	1986	19,507		10			19,507	52
53	PAINTING	1987	9,922		3			9,922	53
54	STEEL DOOR	1987	6,020		10			6,020	54
55	WINDOW REPLACEMENT	1987	2,013		10			2,013	55
56	GENERATOR SWITCH	1988	3,335		10			3,335	56
57	REMODEL LOBBY	1989	156,996	5,233	30	5,233		97,250	57
58	BUS HUT	1989	4,715		15			4,715	58
59	WATER HEATER	1989	6,721		10			6,721	59
60	TRANSFER SWITCH	1989	1,127		10			1,127	60
61	HEAT-ENERGY PANEL	1989	8,633		10			8,633	61
62	LEASEHOLD IMPROVEMENTS	1989	6,629		10			6,629	62
63	ROOF REPAIR	1990	6,928		10			6,928	63
64	REMODELING	1990	6,953	232	30	232		4,210	64
65	OVERHEAD DOOR	1990	1,220		10			1,220	65
66	KITCHEN TANKS	1990	3,089		10			3,089	66
67	PLASTERING	1990	2,586		10			2,586	67
68	REMODEL CEILING	1990	2,970		10			2,970	68
69	LEASEHOLD IMPROVEMENTS	1990	26,015		10			26,015	69
70	TOTAL (lines 4 thru 69)		\$ 4,680,671	\$ 5,465		\$ 111,757	\$ 106,292	\$ 2,803,429	70

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

Facility Name &amp; ID Number Brother James Court

# 0020495

Report Period Beginning:

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Ending:

06/30/08

**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	<b>Totals from Page 12A, Carried Forward</b>		\$ 4,680,671	\$ 5,465		\$ 111,757	\$ 106,292	\$ 2,803,429	1
2	LEASEHOLD IMPROVEMENTS	1991	2,141		10			2,141	2
3	WINDOW REPLACEMENT	1992	2,750		10			2,750	3
4	CARETERIA DOORS	1993	11,918		10			11,918	4
5	PLUMBING WORK	1994	6,858		10			6,858	5
6	PAINTING	1995	3,076		10			3,076	6
7	WALL AND DOOR REPAIR	1995	2,596		10			2,596	7
8	DOOR	1996	656		10			656	8
9	ROOF REPAIR	1996	5,985		10			5,985	9
10	PAINTING	1996	1,620		3			1,620	10
11	FURNACE	1996	502		10			502	11
12	LAND IMPROVEMENTS	1996	1,385		3			1,385	12
13	REPAIRS	1996	10,702		5			10,702	13
14	GRIP CAPS	1996	1,575		5			1,575	14
15	BOILER	1996	3,335		10			3,335	15
16	BEDDING	1996	1,505		3			1,505	16
17	AIR DEFLECTORS	1996	381		3			381	17
18	SHOWER	1996	259		5			259	18
19	SEWER	1996	9,387		10			9,387	19
20	PAINTING	1996	4,928		10			4,928	20
21	ROOF REPAIR	1997	798		10			798	21
22	DRAPES	1997	4,500		5			4,500	22
23	FLOOR COVERINGS	1997	1,722		10			1,722	23
24	DRAPES - LIFE CENTER	1997	3,153		5			3,153	24
25	FLOOR COVERING - LIFE CENTER	1997	4,422		10			4,422	25
26	PAINTING - LIFE CENTER	1997	8,917		10			8,917	26
27	FLOOR	1997	2,658		10			2,658	27
28	ALARM/SMOKE DETECTORS	1998	20,108		5			20,108	28
29	SNACK LOUNGE REMODELING	1999	2,847		5			2,847	29
30	ROOF REPAIRS	1999	846	85	10	85		783	30
31	CARPET - FRONT OFFICE	1999	8,881		5			8,881	31
32	YARD SIGNS	1999	2,825	283	10	283		2,566	32
33	NEW TEES AND VALVES	1999	11,685	1,169	10	1,169		10,614	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 4,825,592	\$ 7,002		\$ 113,294	\$ 106,292	\$ 2,946,957	34

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

Facility Name &amp; ID Number Brother James Court

# 0020495

Report Period Beginning:

07/01/07

Ending:

06/30/08

**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	<b>Totals from Page 12B, Carried Forward</b>		\$ 4,825,592	\$ 7,002		\$ 113,294	\$ 106,292	\$ 2,946,957	1
2	VINYL WALL COVERING	1999	1,127	113	10	113		1,014	2
3	SHOWER ROOM REPAIRS	1999	8,220	822	10	822		7,398	3
4	CONNECTION FEES FOR SEWER PROJECT	1998	7,438	744	10	744		7,128	4
5	TREE REMOVAL	1999	9,857	986	10	986		8,707	5
6	CONDENSOR	1999	12,396	1,240	10	1,240		10,950	6
7	LEASEHOLD IMPROVEMENTS	1999	2,598		5			2,598	7
8	LANDSCAPING	1999	18,255	1,826	10	1,826		15,896	8
9	DROP ROD ASSEMBLY	1999	6,408	641	10	641		5,607	9
10	FENCING	1999	3,840	384	10	384		3,328	10
11	TREES	1999	9,905	991	10	991		8,502	11
12	ROOF REPAIRS	2000	2,300	230	10	230		1,917	12
13	TILE FLOOR - RESIDENT WING	2000	34,740	3,474	10	3,474		28,950	13
14	PAINTING	2000	6,352		5			6,352	14
15	WINDOW REPLACEMENT	2000	2,009	201	10	201		1,657	15
16	LEASEHOLD IMPROVEMENTS	2000	5,754		5			5,754	16
17	CABINET MODIFICATIONS	1999	4,520		7			4,520	17
18	PROFESSIONAL ELECTRICAL SERVICES	1999	17,410	1,161	15	1,161		10,446	18
19	NEW SIGN FRONT	1999	900		5			900	19
20	BJC - MASONRY WORK	1999	23,465	1,564	15	1,564		14,079	20
21	PROFESSIONAL; PLUMBING AND HEATING	1999	3,100	2,067	15	2,067		18,600	21
22	REMODELING	1999	19,524	1,302	15	1,302		11,714	22
23	PARKING LOT STRIPING	2000	1,549		5			1,549	23
24	PAINT BASEMENT CEILING	2000	664		5			664	24
25	DRAPERIES	2001	10,881		5			10,881	25
26	RAMP AREA DECORATING	2001	14,387		5			14,387	26
27	PAINTING AND WALLCOVERING	2001	8,058		5			8,058	27
28	AIR CURTAIN	2001	1,812	259	7	259		1,769	28
29	RECEPTICLES - BEDROOMS	2001	9,820		5			9,820	29
30	SHOWER ROOM FLOOR REPAIRS	2002	1,123	112	10	112		730	30
31	DOOR REPAIRS	2002	6,197	620	10	620		3,936	31
32	BOILER REPAIRS	2002	3,960		5			3,960	32
33	DRAPERIES	2002	4,200		5			4,200	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 5,088,361	\$ 25,739		\$ 132,031	\$ 106,292	\$ 3,182,928	34

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

Facility Name &amp; ID Number Brother James Court

# 0020495

Report Period Beginning:

07/01/07

Ending:

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**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	<b>Totals from Page 12C, Carried Forward</b>		\$ 5,088,361	\$ 25,739		\$ 132,031	\$ 106,292	\$ 3,182,928	1
2	ARCHITECT FEES - REMODEL BATHROOM AREAS	2002	9,863		3			9,863	2
3	REPAVE SIDEWALKS	2002	810	81	10	81		506	3
4	TUCKPOINTING	2002	1,490	149	10	149		919	4
5	REPAIR FLOORS	2002	2,688	269	10	269		1,658	5
6	KEYLOCK PAD	2002	580	58	10	58		343	6
7	STRIP AND REFINISH FLOORS	2002	8,702	870	10	870		4,952	7
8	HAT WATER STORAGE TANK	2002	4,408	441	10	441		2,425	8
9	DOORS AND FRAMES	2003	3,733	373	10	373		1,960	9
10	POLE LIGHTING - WEST PARKING LOT	2004	3,740	249	15	249		1,143	10
11	SINK FAUCET AND CABINET	2004	1,133	162	7	162		701	11
12	WALLPAPERING/PAINTING	2004	2,358	157	15	157		629	12
13	DOORS AND FRAMES	2004	4,987	332	15	332		1,385	13
14	CEILING FANS	2004	1,082	155	7	155		644	14
15	ELECTRICAL WORK	2004	16,000	1,067	15	1,067		4,267	15
16	ALARM SYSTEM	2004	2,204	315	7	315		1,259	16
17	BOILER - KITCHEN STEAMER	2004	4,871	696	7	696		2,900	17
18	BOILER	2004	6,900	986	7	986		4,354	18
19	BOILER	2004	7,200	1,029	7	1,029		4,114	19
20	TOILER ROOM ADDITION/RENOVATION	2003	699,826	23,328	30	23,328		105,688	20
21									21
22	HVAC LABOR/MATERIAL	2004	12,497	1,785	7	1,785		6,992	22
23	PARKING LOT	2004	74,847	2,495	30	2,495		9,772	23
24	DENTAL OFFICE RENOVATION	2004	57,955	1,932	30	1,932		7,244	24
25	POLE LIGHT REPLACEMENT	2004	1,868	267	7	267		978	25
26	PARKING LOT SECURITY SYSTEM	2005	20,404	2,915	7	2,915		10,193	26
27	STORAGE ROOM	2005	2,375	339	7	339		1,301	27
28	BATHROOM REPAIR	2006	4,232	846	5	846		2,469	28
29	ALARM FOR BUILDING	2006	3,000	300	10	300		825	29
30	ALARM FOR BUILDING	2006	3,041	304	10	304		786	30
31	ROOF	2006	22,370	1,119	20	1,119		2,889	31
32	WATER HEATER	2006	32,250	3,225	10	3,225		7,794	32
33	BOILER	2007	4,611	659	7	659		1,098	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 6,110,386	\$ 72,642		\$ 178,934	\$ 106,292	\$ 3,384,979	34

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

Facility Name & ID Number Brother James Court

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Report Period Beginning:

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06/30/08

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 6,110,386	\$ 72,642		\$ 178,934	\$ 106,292	\$ 3,384,979	1
2	BATHROOM REPAIRS	2007	6,959	994	7	994		1,657	2
3	GENERATOR	2007	2,814	563	5	563		891	3
4	ALARM FOR BUILDING	2007	3,325	333	10	333		360	4
5	NEW ROOF	2008	90,882	2,777	30	2,777		2,777	5
6	EXTERIOR FLOOD LIGHTS	2008	945	79	10	79		79	6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,215,311	\$ 77,388		\$ 183,680	\$ 106,292	\$ 3,390,743	34

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

Facility Name & ID Number Brother James Court # 0020495 Report Period Beginning: 07/01/07 Ending: 06/30/08

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	\$ 244,958	\$ 32,728	\$ 32,728	\$		\$ 184,672	71
72	Current Year Purchases	43,591	1,783	1,783			1,783	72
73	Fully Depreciated Assets	1,448,347	922	922			1,448,347	73
74								74
75	TOTALS	\$ 1,736,896	\$ 35,433	\$ 35,433	\$		\$ 1,634,802	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility Use	Trucks	Various	\$ 69,569	\$	\$	\$		\$ 69,569	76
77	Resident Transportation	Vans/Wheelchair Lift	Various	70,019	7,119	7,119			42,730	77
78	Resident Transportation	Autos - Fully Depreciated	Various	39,323					39,323	78
79	Resident Transportation	Autos - 06 Buick/98 Buick	2006/2007	21,916	4,860	4,860			11,890	79
80	TOTALS			\$ 200,827	\$ 11,979	\$ 11,979	\$		\$ 163,512	80

E. Summary of Care-Related Assets

	1	Reference	2	
			Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 8,153,034	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 124,800	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 231,092	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 106,292	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 5,189,057	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Brother James Court

# 0020495

Report Period Beginning: 07/01/07

Ending: 06/30/08

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: FRANCISCAN BROTHERS OF THE HOLY CROSS

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	<b>TOTAL</b>				\$			7

10. Effective dates of current rental agreement:

Beginning 1975

Ending 2011

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

Fiscal Year Ending                      Annual Rent

12.	<u>6/30/2009</u>	\$ <u>270,000</u>
13.	<u>6/30/2010</u>	\$ <u>270,000</u>
14.	<u>6/30/2011</u>	\$ <u>270,000</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

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

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

15. Is Movable equipment rental included in building rental?

YES  NO

16. Rental Amount for movable equipment: \$ NONE Description: \_\_\_\_\_

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

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

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA <u>40</u></p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA <u>80</u></p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies		533		533
3	Classroom Wages (a)		7,017		7,017
4	Clinical Wages (b)		14,174		14,174
5	In-House Trainer Wages (c)		5,639		5,639
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 27,363	\$	\$ 27,363
10	SUM OF line 9, col. 1 and 2 (e)	\$	27,363		

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	18
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	<b>18</b>

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

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

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

	Service	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		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	<b>TOTAL</b>			\$		\$	\$		\$	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.**

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

Ending:

06/30/08

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/08

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 1,748,489	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	850,287		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 2,598,776	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	1,381,645		12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	1,865,574		15
16	Equipment, at Historical Cost	1,916,526		16
17	Accumulated Depreciation (book methods)	(2,567,874)		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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 2,595,871	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 5,194,647	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 78,818	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	95,793		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
	<b>Other Current Liabilities(specify):</b>			
36	<u>ACCRUED VACATION</u>	73,717		36
37	<u>ACCRUED PENSION, OTHER W/H</u>	80,345		37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 328,673	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 328,673	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 4,865,974	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 5,194,647	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>4,466,785</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>4,466,785</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>399,189</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>399,189</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>4,865,974</b>	<b>24</b> *

\* This must agree with page 17, line 47.

Facility Name & ID Number Brother James Court# 0020495Report Period Beginning: 07/01/07Ending: 06/30/08**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 4,198,185	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 4,198,185	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	18,315	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	7,577	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 25,892	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	317,360	24
25	Interest and Other Investment Income***	130,750	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 448,110	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>RENTAL INCOME</b>	1,350	28
28a	<b>MISC &amp; NURSING INCOME</b>	29,379	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 30,729	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 4,702,916	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	837,354	31
32	Health Care	1,767,488	32
33	General Administration	1,071,743	33
<b>B. Capital Expense</b>			
34	Ownership	394,800	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers		35
36	Provider Participation Fee	232,342	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 4,303,727	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	399,189	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 399,189	43

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

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

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

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

Facility Name & ID Number Brother James Court

# 0020495

Report Period Beginning: 07/01/07

Ending:

06/30/08

**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	1,909	2,080	\$ 58,341	\$ 28.05	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses	15,868	17,004	294,643	17.33	4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,932	2,086	22,894	10.98	8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers	1,959	2,120	37,001	17.45	11
12	Dietician					12
13	Food Service Supervisor	2,024	2,188	37,352	17.07	13
14	Head Cook					14
15	Cook Helpers/Assistants	19,150	20,537	185,658	9.04	15
16	Dishwashers					16
17	Maintenance Workers	3,814	4,248	56,407	13.28	17
18	Housekeepers	4,947	5,555	53,304	9.60	18
19	Laundry	4,365	4,825	58,165	12.05	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative	13,984	15,073	228,137	15.14	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	7,820	8,449	114,358	13.54	28
29	Resident Services Coordinator	1,940	2,081	44,227	21.25	29
30	Habilitation Aides (DD Homes)	100,199	107,226	1,077,849	10.05	30
31	Medical Records	6	6	55	9.17	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	179,917	193,478	\$ 2,268,391 *	\$ 11.72	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	95	\$ 3,561	1,3	35
36	Medical Director	Various	2,000	9,3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Various	1,200	10,3	39
40	Physical Therapy Consultant	58	3,204	10a,3	40
41	Occupational Therapy Consultant	13	596	10a,3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	Various	2,600	10a,3	43
44	Activity Consultant				44
45	Social Service Consultant	Various	6,000	12,3	45
46	Other(specify)				46
47	Psychology Consultant	Various	13,632	10a,3	47
48					48
49	TOTAL (lines 35 - 48)	166	\$ 32,793		49

**C. CONTRACT NURSES**

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

Facility Name & ID Number Brother James Court

# 0020495

Report Period Beginning: 07/01/07

Ending: 06/30/08

**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	
			\$	Workers' Compensation Insurance	\$ 101,354	IDPH License Fee	\$	
				Unemployment Compensation Insurance	27,155	Advertising: Employee Recruitment	5,918	
				FICA Taxes	162,723	Health Care Worker Background Check	792	
				Employee Health Insurance	103,559	(Indicate # of checks performed <u>59</u> )		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Dues and Subscriptions	1,403	
				401(k) Contribution	80,345			
				Life Insurance	8,595			
				Education	1,458			
				Staff Recognition	5,004	Less: Public Relations Expense	( )	
				Employee Physicals/Drug Tests	6,680	Non-allowable advertising	( )	
						Yellow page advertising	( )	
TOTAL (agree to Schedule V, line 17, col. 1)			\$	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
(List each licensed administrator separately.)				\$ 496,873		\$ 8,113		
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
			\$			\$	Out-of-State Travel	\$
							In-State Travel	
							Seminar Expense	
							Entertainment Expense	( )
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	
(Attach a copy of any management service agreement)							\$	
C. Professional Services								
Vendor/Payee	Type	Amount						
Sikich	Audit	\$ 16,914						
Zielinski & Assoc	Consulting	66,739						
INB	Trust Admin	7,297						
See Attached	Legal	11,141						
TOTAL (agree to Schedule V, line 19, column 3)			\$					
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 102,091					

\* Attach copy of IMRF notifications

\*\*See instructions.



**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No  
If YES, give association name and amount. \_\_\_\_\_
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 7
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 281 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. 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.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 232,342  
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? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? 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. \$ None Has any meal income been offset against related costs? N/A Indicate the amount. \$ N/A
- (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? Yes If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 7,578  
c. What percent of all travel expense relates to transportation of nurses and patients? 100%  
d. Have vehicle usage logs been maintained? Yes  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes  
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: Sikich 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? Yes If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.