



Facility Name & ID Number St Andrew Life Center

# 0044776 Report Period Beginning: 07/01/2007 Ending: 06/30/2008

**III. STATISTICAL DATA**

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

N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	55	Intermediate (ICF)	55	20,130	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	55	TOTALS	55	20,130	7

**B. Census-For the entire report period.**

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED	8,092	11,626		19,718	9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	8,092	11,626		19,718	14

**C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.)** 97.95%

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

184 (Do not include bed-hold days in Section B.)

**E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)**

None

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

Yes

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

YES  NO

Note: Non-allowable costs have been eliminated in Schedule V, Column 7.

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

YES  NO

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

Date started 03/01/2000

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

YES  Date 03/01/2000 NO

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

YES  NO  If YES, enter number of beds certified \_\_\_\_\_ and days of care provided 0

Medicare Intermediary N/A

**IV. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 06/30/08 Fiscal Year: 06/30/08

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

Facility Name & ID Number St Andrew Life Center # 0044776 Report Period Beginning: 07/01/2007 Ending: 06/30/2008

**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	399,038	47,017	29,064	475,119		475,119	(293,593)	181,526		1
2	Food Purchase		374,414		374,414		374,414	(237,011)	137,403		2
3	Housekeeping	201,898	5,805		207,703		207,703	(128,347)	79,356		3
4	Laundry	34,778	21,015	782	56,575		56,575	(34,960)	21,615		4
5	Heat and Other Utilities			297,681	297,681		297,681	(183,947)	113,734		5
6	Maintenance	204,156	29,645	165,509	399,310		399,310	(245,402)	153,908		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	839,870	477,896	493,036	1,810,802		1,810,802	(1,123,260)	687,542		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			12,000	12,000		12,000		12,000		9
10	Nursing and Medical Records	896,126	38,309	12,615	947,050		947,050		947,050		10
10a	Therapy	4,394			4,394		4,394		4,394		10a
11	Activities	305,947	5,365	5,915	317,227		317,227		317,227		11
12	Social Services	36,710		2,200	38,910		38,910		38,910		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <b>Assisted Living</b>	247,139	2,460	26,992	276,591		276,591	(276,591)			15
16	<b>TOTAL Health Care and Programs</b>	1,490,316	46,134	59,722	1,596,172		1,596,172	(276,591)	1,319,581		16
	<b>C. General Administration</b>										
17	Administrative	93,054		444,613	537,667		537,667	(444,613)	93,054		17
18	Directors Fees										18
19	Professional Services										19
20	Dues, Fees, Subscriptions & Promotions			10,651	10,651		10,651		10,651		20
21	Clerical & General Office Expenses	143,087	24,778	59,731	227,596		227,596	344,684	572,280		21
22	Employee Benefits & Payroll Taxes			935,510	935,510		935,510	(164,963)	770,547		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,626	2,626		2,626		2,626		24
25	Other Admin. Staff Transportation			1,672	1,672		1,672		1,672		25
26	Insurance-Prop.Liab.Malpractice			192,046	192,046		192,046		192,046		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	236,141	24,778	1,646,849	1,907,768		1,907,768	(264,892)	1,642,876		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,566,327	548,808	2,199,607	5,314,742		5,314,742	(1,664,743)	3,649,999		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 &amp; ID Number

St Andrew Life Center

#0044776

Report Period Beginning:

07/01/2007

Ending:

06/30/2008

## 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			641,031	641,031		641,031	(354,825)	286,206			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							7,578	7,578			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			2,302	2,302		2,302		2,302			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			643,333	643,333		643,333	(347,247)	296,086			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		178,350		178,350		178,350		178,350			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			30,195	30,195		30,195		30,195			42
43	Other (specify):* <b>Nonallowable costs</b>			54,504	54,504		54,504	(54,504)				43
44	<b>TOTAL Special Cost Centers</b>		178,350	84,699	263,049		263,049	(54,504)	208,545			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,566,327	727,158	2,927,639	6,221,124		6,221,124	(2,066,494)	4,154,630			45

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

**VI. ADJUSTMENT DETAIL**

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(5,648)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(54,504)	43		25
	Income Taxes and Illinois Personal				
26	Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule <u>From Pg 5A</u>	(2,076,436)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (2,136,588)		\$	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)	70,094		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 70,094		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (2,066,494)		37

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

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

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

BHF USE ONLY							
48		49		50		51	
						52	

SEE ACCOUNTANTS' COMPILATION REPORT

St Andrew Life Center

ID# 0044776

Report Period Beginning: 07/01/2007

Ending: 06/30/2008

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1		\$		1
2	Disallow assisted living wage	(247,139)	15	2
3	Disallow assisted living supplies	(2,460)	15	3
4	Disallow assisted living expenses	(26,992)	15	4
5	Disallow benefit allocated to assisted living	(286,118)	22	5
6	Disallow depreciation allocated to assisted living	(396,115)	30	6
7	Disallow maintenance expense allocated to assisted living	(246,748)	6	7
8	Disallow utilities expense allocated to assisted living	(183,947)	5	8
9	Disallow housekeeping allocated to assisted living	(128,347)	3	9
10	Disallow dietary wages allocated to assisted living	(293,593)	1	10
11	Disallow food expense allocated to assisted living	(231,363)	2	11
12	Disallow laundry expense allocated to assisted living	(34,960)	4	12
13				13
14	Reclass R & M for HFS capitalization requirements	1,346	6	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>	(2,076,436)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number St Andrew Life Center# 0044776

Report Period Beginning:

07/01/2007

Ending:

06/30/2008

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	(293,593)	0	0	0	0	0	0	0	0	0	0	(293,593)	1
2	Food Purchase	(237,011)	0	0	0	0	0	0	0	0	0	0	(237,011)	2
3	Housekeeping	(128,347)	0	0	0	0	0	0	0	0	0	0	(128,347)	3
4	Laundry	(34,960)	0	0	0	0	0	0	0	0	0	0	(34,960)	4
5	Heat and Other Utilities	(183,947)	0	0	0	0	0	0	0	0	0	0	(183,947)	5
6	Maintenance	(245,402)	0	0	0	0	0	0	0	0	0	0	(245,402)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(1,123,260)</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>(1,123,260)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
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):*	(276,591)	0	0	0	0	0	0	0	0	0	0	(276,591)	15
16	<b>TOTAL Health Care and Programs</b>	<b>(276,591)</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>(276,591)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	(444,613)	0	0	0	0	0	0	0	0	0	(444,613)	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	344,684	0	0	0	0	0	0	0	0	0	344,684	21
22	Employee Benefits & Payroll Taxes	(286,118)	121,155	0	0	0	0	0	0	0	0	0	(164,963)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(286,118)</b>	<b>21,226</b>	<b>0</b>	<b>(264,892)</b>	<b>28</b>								
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(1,685,969)</b>	<b>21,226</b>	<b>0</b>	<b>(1,664,743)</b>	<b>29</b>								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number St Andrew Life Center

# 0044776

Report Period Beginning:

07/01/2007

Ending:

06/30/2008

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 TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(396,115)	41,290	0	0	0	0	0	0	0	0	0	(354,825)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	7,578	0	0	0	0	0	0	0	0	0	7,578	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(396,115)</b>	<b>48,868</b>	<b>0</b>	<b>(347,247)</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):*	(54,504)	0	0	0	0	0	0	0	0	0	0	(54,504)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(54,504)</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>(54,504)</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(2,136,588)</b>	<b>70,094</b>	<b>0</b>	<b>(2,066,494)</b>	<b>45</b>								

Facility Name & ID Number

St Andrew Life Center

# 0044776

Report Period Beginning:

07/01/2007

Ending:

06/30/2008

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Resurrection Health Care	100	See Attached		See Attached		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: 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		\$ 344,684	\$ 344,684	1
2	V	22 Employee Benefits		Resurrection Health Care		121,155	121,155	2
3	V	30 Depreciation		Resurrection Health Care		41,290	41,290	3
4	V	32 Interest		Resurrection Health Care		7,578	7,578	4
5	V							5
6	V							6
7	V	17 Intercompany Accrual	444,613	Resurrection Health Care			(444,613)	7
8	V	39 Intercompany Pharmacy	176,223	Resurrection Health Care		176,223		8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 620,836			\$ 690,930	\$ * 70,094	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Andrew Life Center # 0044776 Report Period Beginning: 07/01/2007 Ending: 06/30/2008

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference
						Hours	Percent	Description	Amount	
1	See attached pg. 7A								\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Andrew Life Center

# 0044776 Report Period Beginning: 07/01/2007

Ending: 6/30/2008

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 West 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			\$	\$		\$ 344,684	1
2	22	Employee Benefits						121,155	2
3	30	Depreciation						41,290	3
4	32	Interest						7,578	4
5									5
6									6
7	39	Intercompany Pharmacy						176,223	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				\$	\$		\$ 690,930	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

St Andrew Life Center

# 0044776

Report Period Beginning:

07/01/2007

Ending:

06/30/2008

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		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							\$	\$				\$						
2																		
3																		
4																		
5																		
	<b>Working Capital</b>																	
6																		
7																		
8																		
9	<b>TOTAL Facility Related</b>						\$	\$				\$						
	<b>B. Non-Facility Related*</b>																	
10																		
11									Allocated from Home Office			7,578						
12																		
13																		
14	<b>TOTAL Non-Facility Related</b>						\$	\$				7,578						
15	<b>TOTALS (line 9+line14)</b>						\$	\$				7,578						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.      \$   N/A                        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.)

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

**B. Real Estate Taxes**

**Important**, please see the next worksheet, "RE\_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2007 report.

\$ \_\_\_\_\_ 1

2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)

\$ \_\_\_\_\_ 2

3. Under or (over) accrual (line 2 minus line 1).

\$ \_\_\_\_\_ 3

4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)

\$ \_\_\_\_\_ 4

5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C.  
**(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**

\$ \_\_\_\_\_ 5

6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.

**TOTAL REFUND** \$ \_\_\_\_\_ **For** \_\_\_\_\_ **Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**

\$ \_\_\_\_\_ 6

7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.

\$ \_\_\_\_\_ 7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2003	_____	8
	2004	_____	9
	2005	_____	10
	2006	_____	11
	2007	<u>N/A</u>	12

**FOR BHF USE ONLY**

13	FROM R. E. TAX STATEMENT FOR 2007	\$ _____	13
14	PLUS APPEAL COST FROM LINE 5	\$ _____	14
15	LESS REFUND FROM LINE 6	\$ _____	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$ _____	16

**Facility is a not-for-profit entity and does not pay real estate tax.**

**NOTES:**

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

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 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 St Andrew Life Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0044776

CONTACT PERSON REGARDING THIS REPORT Thomas W. Groenwald

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

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

Enter the tax index number and real estate tax assessed for 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. _____	<u>N/A</u>	\$ _____	\$ _____
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        N/A        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 St Andrew Life Center

# 0044776 Report Period Beginning:

07/01/2007 Ending:

06/30/2008

**X. BUILDING AND GENERAL INFORMATION:**

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

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

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

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

Assisted Living & Independent Living

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

1. Total Amount Incurred: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_

3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

Nature of Costs:

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

**XI. OWNERSHIP COSTS:**

A. Land.

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number St Andrew Life Center

# 0044776

Report Period Beginning:

07/01/2007 Ending: 06/30/2008

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	55		2000	1951	\$ 936,802	\$ 24,021	39	\$ 24,021		\$ 268,790	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	Various		2000		5,782		20				9
10											10
11	Vacuum return system (20320)		2001		5,588		20				11
12	Boiler bottom (21955)		2001		6,038		20				12
13	Cross-header shaft (550)		2001		151		20				13
14	T&M Rebuilt (840)		2001		231		20				14
15	Plumbing (536)		2001		147		20				15
16	Bathroom light diffuser (510)		2001		140		20				16
17	Draperies (4300)		2001		1,183		20				17
18	Vertical blinds (1638)		2001		450		20				18
19	Circuit breaker (1519)		2001		418		20				19
20	Limestone repair (32000)		2001		8,800		20				20
21	Roof (7800)		2001		2,145		20				21
22	Elevator (47332)		2001		13,016		20				22
23	Pumps with new HP monitor(15965) - Alloc RHC		2001		4,390		20				23
24	Water leak & insulate (1817) - Alloc RHC		2001		500		20				24
25	Water gaskets (1063)		2002		292		20				25
26	Astro-slide (606)		2002		166		20				26
27	Hot water pump (618)		2002		170		20				27
28	Weiling pump (1568)		2002		431		20				28
29	Landscaping (13550)		2002		3,726		20				29
30	Land study (4175)		2002		1,148		20				30
31	Code review (9772)		2002		2,687		20				31
32	Land study (6925)		2002		1,904		20				32
33	Electrical elevator (8494)		2002		2,336		20				33
34	Carpet (1438)		2002		395		20				34
35	Fire alarm (6771)		2002		1,862		20				35
36											36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number St Andrew Life Center

# 0044776

Report Period Beginning:

07/01/2007 Ending: 06/30/2008

## XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Land study (7710)	2002	\$ 2,120	\$	20	\$	\$	\$	37
38	Electrical work (1465)	2002	403		20				38
39	Architect Fees (11392)	2002	3,133		20				39
40	Fire Alarm (25658)	2002	7,056		20				40
41	Code review (9895)	2002	2,721		20				41
42	Life line Resp. Syst-50% pm (33290) - Alloc RHC	2002	9,155		20				42
43	Refrig. Piping (5000) - Alloc RHC	2002	1,375		20				43
44									44
45	Leak at condenser of freezer (2105) - Alloc RHC	2002	579		20				45
46	Prof Serv - Land Study (1080)	2002	297		20				46
47	Power line for overload panel (5712)	2002	1,571		20				47
48	Refrig piping (4881)	2002	1,342		20				48
49	Asbestos abatement-boiler #1 (15500)	2002	4,263		20				49
50	Fire alarm control panel (2599)	2002	715		20				50
51	Asbestos abatement -Boiler # 1 repair (4675)	2002	1,286		20				51
52	Replace leaking tube - Boiler #3 (1659)	2002	456		20				52
53	Building renovation (4794)	2002	1,318		20				53
54	Building renovation (4590)	2002	1,262		20				54
55	Prof Serv - Toilet renovation (1740)	2002	479		20				55
56	Replace stay bolts - Boiler #1 (2975)	2002	818		20				56
57	Replace leaking tube - Tank #2 (16585)	2002	4,561		20				57
58	Building renovation (152,758)	2002	42,008		20				58
59	Water system (783) *	2002	215		20				59
60	Cable & hose protector (631) *	2002	174		20				60
61	Boiler repair (573) *	2002	158		20				61
62	Replace stay bolts - Boiler #1 (7000)	2003	1,925		20				62
63	Prof serv - Code review (73)	2003	20		20				63
64	Prof serv - toilet renovation (1305)	2003	359		20				64
65	Rebuild firebox (8955)	2003	2,463		20				65
66	Reinsulate two boilers (4675)	2003	1,286		20				66
67	Modify steam supply & piping (25310)	2003	6,960		20				67
68	Replace leaking tubes in boiler (12695)	2003	3,491		20				68
69	Replace stairs & rails (5200)	2003	1,430		20				69
70	TOTAL (lines 4 thru 69)		\$ 1,106,297	\$ 24,021		\$ 24,021	\$	\$ 268,790	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number St Andrew Life Center

# 0044776

Report Period Beginning:

07/01/2007 Ending: 06/30/2008

## 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>		\$ 1,106,297	\$ 24,021		\$ 24,021	\$	\$ 268,790	1
2	Lifeline response systems (69,519)	2003	19,118		20				2
3	Install new floor & base (4071)	2003	1,120		20				3
4	Demolition (23,200) **	2003	6,380		20				4
5	Prof. serv - Code Review (50) **	2003	14		20				5
6	Furnish wood doors hardware (2288) **	2003	629		20				6
7	Elevator safety tests (4321) **	2003	1,188		20				7
8	Radio system (786) **	2003	216		20				8
9	Filters (826)	2003	227		20				9
10									10
11	Code review	2003	205		20				11
12	Land study	2003	6,743		20				12
13	Appraisal	2004	9,000		20				13
14	Rebuild fire box for boiler	2004	7,250		20				14
15	Data cable installation	2004	2,148		20				15
16	Convent demolition	2004	242,028		20				16
17	Asbestos removal	2004	49,460		20				17
18									18
19	Reseal, stripe parking lot	2005	6,975		10				19
20	Landscaping	2005	10,200		10				20
21	Boiler upgrade	2005	77,205		10				21
22	Roof work	2005	126,868		15				22
23	Utility station - cabinets, flooring, counter tops	2005	29,402		10				23
24	Replace tube bundles	2005	32,450		15				24
25	Furnace stack, hot & chilled water piping	2005	62,392		15				25
26	Stairwell doors	2005	18,121		15				26
27	Safety sensors - front entrance doors	2005	2,468		10				27
28	Emergency boiler repairs	2005	2,965		10				28
29	Wiring	2005	14,300		20				29
30	Flooring tile & installation	2005	11,650		10				30
31	Architectural & planning services from Loeb	2005	250,200		15				31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 2,097,219	\$ 24,021		\$ 24,021	\$	\$ 268,790	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number St Andrew Life Center

# 0044776

Report Period Beginning:

07/01/2007 Ending: 06/30/2008

## 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>		\$ 2,097,219	\$ 24,021		\$ 24,021	\$	\$ 268,790	1
2	Landscape Architectural Services	2006	9,838		7				2
3	Freezer Floor, Material & Installation	2006	2,058		15				3
4	Two Condensate Receiver/Pumps in Boiler Room	2006	8,465		10				4
5	Honeywell controller for 6th floor	2006	2,485		10				5
6	Rockford 3" grease trap in kitchen	2006	2,628		15				6
7	Replace bad convectors with Fin tube radiation	2006	2,741		8				7
8	Boiler upgrade	2006	1,600		15				8
9	4 Detex alarms/lock & keypad	2006	1,295		10				9
10	Install 4 tamper switches for fire protection	2006	2,969		15				10
11									11
12	Entryway medallion	2006	1,668		15				12
13	Cut & removal of 4 dead trees	2006	1,000		7				13
14	Landscape planting at main entrance w/signs	2006	5,000		7				14
15	Pruning & trimming of trees on northside	2006	2,800		5				15
16	Plants	2006	111		5				16
17	Plants	2007	1,079		5				17
18	Landscaping design & architectural services	2007	10,588		10				18
19	Landscape work	2007	425		5				19
20	Custom millwork	2007	5,980		15				20
21	Architectural Services	2007	214,651		20				21
22	Fire alarm upgrade	2007	504,785		20				22
23	Fire department connection charge	2007	150		20				23
24	Fee for professional services-remodeling	2007	2,736		20				24
25	System sales radio	2007	1,495		20				25
26	System sales undetermined	2007	744		20				26
27	Architectural Services	2007	35,135		20				27
28	Architectural Services	2007	11,262		20				28
29	General conditions	2007	485,766		20				29
30	Demolition	2007	172,618		20				30
31	Excavation	2007	7,530		20				31
32	Site concrete	2007	108,898		20				32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 3,705,719	\$ 24,021		\$ 24,021	\$	\$ 268,790	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number St Andrew Life Center

# 0044776

Report Period Beginning:

07/01/2007 Ending: 06/30/2008

**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>		\$ 3,705,719	\$ 24,021		\$ 24,021	\$	\$ 268,790	1
2	Landscaping	2007	27,853		20				2
3	Concrete	2007	15,446		20				3
4	Masonry	2007	89,192		20				4
5	Miscellaneous Metals	2007	51,971		20				5
6	Handrails & railings	2007	13,230		20				6
7	Millwork	2007	343,428		20				7
8	Firecaulking	2007	8,545		20				8
9	Custom aluminum panels	2007	18,980		20				9
10	Sealants & caulking	2007	4,600		20				10
11	Doors, frames & hardware	2007	100,201		20				11
12	Aluminum entrances & glazing	2007	64,784		20				12
13	Automatic doors	2007	5,571		20				13
14	Drywall & plaster	2007	739,174		20				14
15	Ceramic tile	2007	80,178		20				15
16	Terrazzo & refinishing	2007	60,227		20				16
17	Flooring	2007	359,579		20				17
18	Painting	2007	338,126		20				18
19	Temporary structures and coverings	2007	11,700		20				19
20	Interior signage	2007	23,147		20				20
21	Acoustical partitions	2007	2,943		20				21
22	Toilet accessories	2007	24,917		20				22
23	Plumbing & HVAC	2007	555,112		20				23
24	Fire protection	2007	103,248		20				24
25	Electrical	2007	859,463		20				25
26	Permit allowance	2007	802		20				26
27	Change orders fees	2007	1,662		20				27
28	Project management fees	2007	198,984		20				28
29	Contractor contingency	2007	3,095		20				29
30	GLC insurance	2007	48,200		20				30
31	Sub-default insurance	2007	37,430		20				31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 7,897,507	\$ 24,021		\$ 24,021	\$	\$ 268,790	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	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 7,897,507	\$ 24,021		\$ 24,021	\$	\$ 268,790	1
2	Non-illuminated Sign	2007	4,137		20				2
3	Exterior & Parking Lot Lighting	2008	71,997		20				3
4	Installation - Ceiling Tiles	2007	5,560		20				4
5	Stairwell & Entrance Door Alarms & Floor Door Closers	2008	19,623		20				5
6	Suite Security Door & Shower Room Phase 1 -								6
7	Tile & Plumbing	2008	44,283		20				7
8									8
9									9
10									10
11									11
12	Allocated from Home Office					41,290	41,290		12
13	Financial statement depreciation			110,484		110,484		456,075	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)		\$ 8,043,107	\$ 134,505		\$ 175,795	\$ 41,290	\$ 724,865	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,009,838	\$ 107,056	\$ 107,056	\$	10	\$ 319,012	71
72	Current Year Purchases	67,107	3,355	3,355		10	3,355	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,076,945	\$ 110,411	\$ 110,411	\$		\$ 322,367	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 Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 11,720,052	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 244,916	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 286,206	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 41,290	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,047,232	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Non-care bldg & improvements-01	\$ 2,666,530	\$	\$	86
87	Non-care bldg equipment-01	507,976			87
88	Non-care bldg & improvements-03	284,062			88
89	Non-care equipment-03	17,328	396,115	1,973,260	89
90					90
91	TOTALS	\$ 3,475,896	\$ 396,115	\$ 1,973,260	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94	N/A		94
95		\$	95

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

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

**XII. RENTAL COSTS**

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

1. Name of Party Holding Lease: N/A

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

If NO, see instructions.  YES  NO

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

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

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

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

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

15. Is Movable equipment rental included in building rental?

YES  NO

16. Rental Amount for movable equipment: \$ 2,302

Description: Copiers/Printers

(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			N/A		18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending Annual Rent

12. \_\_\_\_\_ /2009 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2010 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2011 \$ \_\_\_\_\_

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

**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)	
<b>TOTAL TRAINED</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.
- 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		hrs	\$		\$			\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(1)	125 hrs	4,394				125	4,394	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				176,223		176,223	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): <u>Oxygen &amp; Supplies</u>	39(2)					2,127		2,127	13
14	<b>TOTAL</b>			\$ 4,394		\$	\$ 178,350	125	\$ 182,744	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number St Andrew Life Center

# 0044776

Report Period Beginning: 07/01/2007

Ending:

06/30/2008

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/2008

(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	\$ 49,185	\$ 49,185	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>155,510</u> )	216,573	216,573	3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	6,815	6,815	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>	\$ 272,573	\$ 272,573	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	2,600,000	2,600,000	13
14	Buildings, at Historical Cost	10,405,273	7,932,358	14
15	Leasehold Improvements, at Historical Cost	110,749	110,749	15
16	Equipment, at Historical Cost	1,972,094	1,076,945	16
17	Accumulated Depreciation (book methods)	(3,020,492)	(3,020,492)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	48,120	48,120	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(46,516)	(46,516)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify): _____			22
23	Other(specify): _____			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 12,069,228	\$ 8,701,164	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 12,341,801	\$ 8,973,737	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 73,304	\$ 73,304	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
	<b>Other Current Liabilities(specify):</b>			
36	<u>Due to Related Entities</u>	6,641,553	6,641,553	36
37	_____			37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 6,714,857	\$ 6,714,857	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>	\$ 6,714,857	\$ 6,714,857	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 5,626,944	\$ 2,258,880	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 12,341,801	\$ 8,973,737	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(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>5,276,121</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Prior Period Adjustment</b>	<b>652,869</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>5,928,990</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(302,046)</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>(302,046)</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>5,626,944</b>	<b>24</b> *

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

SEE ACCOUNTANTS' COMPILATION REPORT

**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.**

**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense**

1

	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 6,418,332	1
2	Discounts and Allowances for all Levels	(929,938)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 5,488,394	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	52,466	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 52,466	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	5,648	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	18,899	16
17	Sale of Drugs	207,286	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	111,012	21
22	Laundry	1,492	22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 344,337	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See Schedule 19A</u>	33,881	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 33,881	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 5,919,078	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	1,810,802	31
32	Health Care	1,596,172	32
33	General Administration	1,907,768	33
	<b>B. Capital Expense</b>		
34	Ownership	643,333	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	232,854	35
36	Provider Participation Fee	30,195	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 6,221,124	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(302,046)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (302,046)	43

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

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

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

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

St. Andrew Life Center  
Provider # 0044776  
7/1/2006 - 6/30/2007

**Schedule 19A**

XVII - Income Statement: Line 28 - Other Revenue

Revenue from Temporary Restricted Funds	7,612
Miscellaneous Revenue	<u>26,269</u>
To Line 28	<u><u>33,881</u></u>

Facility Name & ID Number **St Andrew Life Center**

# **0044776**

Report Period Beginning: **07/01/2007**

Ending: **06/30/2008**

**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	1,776	2,080	\$ 72,027	\$ 34.63	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,064	4,809	145,293	30.21	3
4	Licensed Practical Nurses	8,176	9,431	223,702	23.72	4
5	CNAs & Orderlies	42,492	48,599	448,321	9.22	5
6	CNA Trainees					6
7	Licensed Therapist	120	125	4,394	35.15	7
8	Rehab/Therapy Aides	650	686	6,783	9.89	8
9	Activity Director	1,400	1,712	35,560	20.77	9
10	Activity Assistants	3,386	3,850	56,785	14.75	10
11	Social Service Workers	1,272	1,560	36,710	23.53	11
12	Dietician	180	180	6,010	33.39	12
13	Food Service Supervisor	1,844	2,064	57,098	27.66	13
14	Head Cook	6,417	7,140	100,835	14.12	14
15	Cook Helpers/Assistants	20,927	23,350	235,095	10.07	15
16	Dishwashers					16
17	Maintenance Workers	9,694	10,829	204,156	18.85	17
18	Housekeepers	16,097	18,465	201,898	10.93	18
19	Laundry	3,115	3,497	34,778	9.95	19
20	Administrator	1,688	2,055	93,054	45.28	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,681	8,409	143,087	17.02	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: Assisted Living	14,080	16,308	247,139	15.15	32
33	Other(specify) <u>Religious Wages</u>	9,411	9,487	213,602	22.52	33
34	TOTAL (lines 1 - 33)	154,470	174,636	\$ 2,566,327 *	\$ 14.70	34

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

\*\* See instructions.

**B. CONSULTANT SERVICES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant			35	
36	Medical Director	Monthly	12,000	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 12,000		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	127	4,713	10(3)	51
52	Certified Nurse Assistants/Aides	292	7,902	10(3)	52
53	TOTAL (lines 50 - 52)	419	\$ 12,615		53

SEE ACCOUNTANTS' COMPILATION REPORT

St. Andrew Life Center  
Provider # 0044776  
7/1/2007 - 6/30/2008

Schedule 20A

	<u>Hours</u> <u>Worked</u>	<u>Hours</u> <u>Paid</u>	<u>Wages</u>	<u>Ave. Hrly.</u> <u>Wage</u>
XVIII - Salary & Wages - Line 32 Other Health Care				
Assisted Living	14,080	16,308	247,139	15.15
Total	<u>14,080</u>	<u>16,308</u>	<u>247,139</u>	<u>15.15</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		
Anne Berg	Administrator	0	\$ 93,054	Workers' Compensation Insurance	\$ 38,341	IDPH License Fee	\$ 995		
				Unemployment Compensation Insurance	6,215	Advertising: Employee Recruitment			
				FICA Taxes	168,974	Health Care Worker Background Check			
				Employee Health Insurance	518,215	(Indicate # of checks performed _____)			
				Employee Meals		Patient Background Checks			
				Illinois Municipal Retirement Fund (IMRF)*		Life Services of Illinois Dues	6,361		
				Life Insurance	4,822	IL Council on Long-Term Care Dues	1,829		
				Disability	16,243	Miscellaneous Dues & Subscriptions	1,466		
				Retirement	170,088				
				Employee Morale and Other Benefits	12,612				
				Home Office Allocation	121,155	Less: Public Relations Expense	( )		
				Less Amount Allocated to Assisted Living	(286,118)	Non-allowable advertising	( )		
						Yellow page advertising	( )		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 93,054	TOTAL (agree to Schedule V, line 22, col.8)		\$ 770,547	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 10,651
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 (eliminated in column 7)			\$ 444,613				Out-of-State Travel	\$	
							In-State Travel		
							Seminar Expense		
							See Attached Schedule	2,626	
							Entertainment Expense	( )	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 444,613	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)		\$ 2,626
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	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4		N/A											
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	<b>TOTALS</b>		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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Facility Name & ID Number St Andrew Life Center# 0044776Report Period Beginning: 07/01/2007Ending: 06/30/2008**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? 8190  
If YES, give association name and amount. LSN - 6361; ICLTC - 1859
- (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? 10 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 17,073 Line 10(2)
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 30,195  
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? Yes-Assisted Living For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 5,648
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? 0  
d. Have vehicle usage logs been maintained? N/A  
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? NO  
Firm Name: KPMG, LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Audit not yet 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

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