



Facility Name & ID Number St Benedict Nursing & Rehab

# 0044784 Report Period Beginning: 7/1/2007 Ending: 6/30/2008

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	99	Skilled (SNF)	99	36,234	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	99	TOTALS	99	36,234	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	4,901	11,046	8,149	24,096	8
9	SNF/PED					9
10	ICF	2,121	8,934		11,055	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	7,022	19,980	8,149	35,151	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.01%

D. How many bed-hold days during this year were paid by the Department? 46 (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 3/1/2000

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 3/1/2000 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 99 and days of care provided 7,840

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 6/30/2008 Fiscal Year: 6/30/2008

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

Facility Name & ID Number St Benedict Nursing & Rehab # 0044784 Report Period Beginning: 7/1/2007 Ending: 6/30/2008

**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	445,698	49,881		495,579		495,579	(98,326)	397,253		1
2	Food Purchase		327,638		327,638		327,638	(72,133)	255,505		2
3	Housekeeping	162,366	296		162,662		162,662	(296)	162,366		3
4	Laundry	114,827	53,500		168,327		168,327	(36,671)	131,656		4
5	Heat and Other Utilities			246,068	246,068		246,068	(49,947)	196,121		5
6	Maintenance	121,973	45	130,000	252,018		252,018	(50,660)	201,358		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	<b>844,864</b>	<b>431,360</b>	<b>376,068</b>	<b>1,652,292</b>		<b>1,652,292</b>	<b>(308,033)</b>	<b>1,344,259</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			18,060	18,060		18,060		18,060		9
10	Nursing and Medical Records	2,293,523	133,592	49,679	2,476,794		2,476,794	(22,607)	2,454,187		10
10a	Therapy	208,019	5,255	129,538	342,812		342,812		342,812		10a
11	Activities	249,129	25,904	1,305	276,338		276,338		276,338		11
12	Social Services	112,713	479	2,640	115,832		115,832		115,832		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>2,863,384</b>	<b>165,230</b>	<b>201,222</b>	<b>3,229,836</b>		<b>3,229,836</b>	<b>(22,607)</b>	<b>3,207,229</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	62,819		592,416	655,235		655,235	(592,416)	62,819		17
18	Directors Fees										18
19	Professional Services										19
20	Dues, Fees, Subscriptions & Promotions			13,266	13,266		13,266		13,266		20
21	Clerical & General Office Expenses	141,326	11,555	36,620	189,501		189,501	536,104	725,605		21
22	Employee Benefits & Payroll Taxes			1,397,986	1,397,986		1,397,986	82,701	1,480,687		22
23	Inservice Training & Education										23
24	Travel and Seminar			908	908		908		908		24
25	Other Admin. Staff Transportation			6,664	6,664		6,664		6,664		25
26	Insurance-Prop.Liab.Malpractice			183,186	183,186		183,186		183,186		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	<b>204,145</b>	<b>11,555</b>	<b>2,231,046</b>	<b>2,446,746</b>		<b>2,446,746</b>	<b>26,389</b>	<b>2,473,135</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>3,912,393</b>	<b>608,145</b>	<b>2,808,336</b>	<b>7,328,874</b>		<b>7,328,874</b>	<b>(304,251)</b>	<b>7,024,623</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.

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 Benedict Nursing &amp; Rehab

#0044784

Report Period Beginning:

7/1/2007

Ending:

6/30/2008

## 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			243,972	243,972		243,972	64,511	308,483			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			9,244	9,244		9,244	(9,244)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			3,032	3,032		3,032		3,032			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			256,248	256,248		256,248	55,267	311,515			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		709,950		709,950		709,950		709,950			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			54,351	54,351		54,351		54,351			42
43	Other (specify):* <b>Non-allowable cost</b>	94,926		15,666	110,592		110,592	(110,592)				43
44	<b>TOTAL Special Cost Centers</b>	94,926	709,950	70,017	874,893		874,893	(110,592)	764,301			44
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	4,007,319	1,318,095	3,134,601	8,460,015		8,460,015	(359,576)	8,100,439			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	(6,661)	2		4
5	Telephone, TV & Radio in Resident Rooms	(2,430)	21		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	(21,084)	32		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				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg 5A	(524,067)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (554,242)		\$	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)	194,666		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 194,666		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (359,576)		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 Benedict Nursing &amp; Rehab

ID# 0044784

Report Period Beginning: 7/1/2007

Ending: 6/30/2008

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Disallow Assisted Living wages	\$ (94,926)	43	1
2	Disallow employee benefits allocated to Assisted Living	(89,496)	22	2
3	Disallow maintenance salaries allocated to Assisted Living	(50,660)	6	3
4	Disallow utilities allocated to Assisted Living	(49,947)	6	4
5	Disallow dietary salaries allocated to Assisted Living	(98,326)	1	5
6	Disallow food expense allocated to Assisted Living	(65,472)	1	6
7	Disallow laundry salaries allocated to Assisted Living	(36,671)	4	7
8				8
9	Offset Housekeeping Revenue	(296)	3	9
10	Offset Medical Records Revenue	(22,607)	10	10
11				11
12	Disallow non-allowable marketing expense	(15,666)	43	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>	(524,067)		49

SEE ACCOUNTANTS' COMPILATION REPORT

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number St Benedict Nursing & Rehab# 0044784

Report Period Beginning:

7/1/2007

Ending:

6/30/2008

## 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	(163,798)	0	0	0	0	0	0	0	0	0	0	(163,798)	1
2	Food Purchase	(6,661)	0	0	0	0	0	0	0	0	0	0	(6,661)	2
3	Housekeeping	(296)	0	0	0	0	0	0	0	0	0	0	(296)	3
4	Laundry	(36,671)	0	0	0	0	0	0	0	0	0	0	(36,671)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(100,607)	0	0	0	0	0	0	0	0	0	0	(100,607)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(308,033)</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>(308,033)</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	(22,607)	0	0	0	0	0	0	0	0	0	0	(22,607)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>(22,607)</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>(22,607)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	(592,416)	0	0	0	0	0	0	0	0	0	(592,416)	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	(2,430)	538,534	0	0	0	0	0	0	0	0	0	536,104	21
22	Employee Benefits & Payroll Taxes	(89,496)	172,197	0	0	0	0	0	0	0	0	0	82,701	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>(91,926)</b>	<b>118,315</b>	<b>0</b>	<b>26,389</b>	<b>28</b>								
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(422,566)</b>	<b>118,315</b>	<b>0</b>	<b>(304,251)</b>	<b>29</b>								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number St Benedict Nursing & Rehab # 0044784 Report Period Beginning: 7/1/2007 Ending: 6/30/2008

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	0	64,511	0	0	0	0	0	0	0	0	0	64,511	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(21,084)	11,840	0	0	0	0	0	0	0	0	0	(9,244)	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>(21,084)</b>	<b>76,351</b>	<b>0</b>	<b>55,267</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):*	(110,592)	0	0	0	0	0	0	0	0	0	0	(110,592)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(110,592)</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>(110,592)</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(554,242)</b>	<b>194,666</b>	<b>0</b>	<b>(359,576)</b>	<b>45</b>								

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:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	21 Clerical & data processing	\$	Resurrection Health Care	100.00%	\$ 538,534	\$ 538,534	1
2	V	22 Employee benefits		Resurrection Health Care	100.00%	172,197	172,197	2
3	V	30 Depreciation		Resurrection Health Care	100.00%	64,511	64,511	3
4	V	32 Interest		Resurrection Health Care	100.00%	11,840	11,840	4
5	V							5
6	V							6
7	V	17 Intercompany expense	592,416	Resurrection Health Care	100.00%		(592,416)	7
8	V	39 Intercompany pharmacy	709,950	Resurrection Health Care	100.00%	709,950		8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,302,366			\$ 1,497,032	\$ * 194,666	14

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

Facility Name & ID Number St Benedict Nursing & Rehab # 0044784 Report Period Beginning: 7/1/2007 Ending: 6/30/2008

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 Benedict Nursing & Rehab

# 0044784

Report Period Beginning:

7/1/2007

Ending: 5/30/2008

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) 594-7888

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			\$	\$		\$ 538,534	1
2	22	Employee benefits						172,197	2
3	30	Depreciation						64,511	3
4	32	Interest						11,840	4
5									5
6									6
7	39	Intercompany Pharmacy						709,950	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				\$	\$		\$ 1,497,032	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

St Benedict Nursing & Rehab

# 0044784

Report Period Beginning:

7/1/2007

Ending:

6/30/2008

**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**					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									Investment Fees		9,244	10					
11									Allocated from Home Office		11,840	11					
12									Interest Income Offset		(11,840)	12					
13									Disallow non-allowable interest		(9,244)	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.      \$ 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.)		\$	N/A
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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	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	N/A	12
<b>Facility is a not-for-profit entity and pays no real estate tax.</b>			
	<b>FOR BHF USE ONLY</b>		
	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

**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.**

SEE ACCOUNTANTS' COMPILATION REPORT

**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 Benedict Nursing & Rehab COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0044784

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        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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Benedict Nursing & Rehab

# 0044784

Report Period Beginning:

7/1/2007

Ending:

6/30/2008

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 56,961 B. General Construction Type: Exterior Brick Frame Metal Number of Stories 2

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).

Independent Living Units

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

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

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

**XI. OWNERSHIP COSTS:**

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>		<u>2000</u>	<u>\$ 3,157,190</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>			<b>\$ 3,157,190</b>	<b>3</b>

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number St Benedict Nursing &amp; Rehab

# 0044784

Report Period Beginning:

7/1/2007

Ending:

6/30/2008

**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	99		2000	1991	\$ 4,247,413	\$	35	\$	\$	\$	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9		Carpet 1st & 2nd floor halls, dining & patient rooms	2000		48,482		10				9
10		Facility sign	2000		7,845		10				10
11		Grease Basin	2000		17,015		7				11
12		Alternator switches	2001		631		10				12
13		Lawn sprinkler system	2001		756		10				13
14		High velocity water jet	2000		322		10				14
15		Catch basin	2000		1,029		10				15
16		Sewer ejector pump repairs	2001		3,194		10				16
17		Sewer ejector pump repairs	2001		2,556		10				17
18		Replacement of hot water systems	2001		11,840		20				18
19		Replacement of hot water systems	2001		11,840		20				19
20		Asbestos removal from boiler	2001		10,156		10				20
21		HVAC	2001		1,523		10				21
22		Carpet	2001		804		7				22
23		HVAC	2001		1,395		10				23
24		Valve	2001		798		10				24
25		Hot water system	2001		11,840		20				25
26		Hot water tank	2001		3,013		20				26
27		Refrigeration lines	2001		1,094		10				27
28		Electrical	2001		3,529		10				28
29		Boiler pipe	2001		1,748		10				29
30		Expansion study	2001		15,503		20				30
31		Voice cables	2001		747		10				31
32		Professional services	2002		9,129		15				32
33		Wreck building	2002		8,804		15				33
34		Antenna	2002		3,917		10				34
35		Circulating pump	2003		2,111		10				35
36		Receivers	2003		18,090		5				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 Benedict Nursing &amp; Rehab

# 0044784

Report Period Beginning:

7/1/2007

Ending:

6/30/2008

## 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	Condensing unit	2003	\$ 4,167	\$	15	\$	\$	\$	37
38	Conduits	2003	2,676		20				38
39	Fire alarm	2001	423		7				39
40	Fire alarm	2001	1,811		7				40
41	Door	2002	603		10				41
42	Pump	2002	989		10				42
43	Power lines	2002	603		10				43
44	Pump catch basin	2002	563		10				44
45	Swing door	2002	708		10				45
46	Fire protection	2002	1,811		7				46
47	Air conditioning	2002	812		10				47
48	Air conditioning	2002	451		10				48
49	Refrigerator ball valves	2002	717		10				49
50	Air conditioning	2002	714		10				50
51	Air conditioning	2002	1,356		10				51
52	Refrigerator ball valves	2002	1,104		10				52
53	Freezer	2002	1,817		10				53
54	Valve	2002	564		10				54
55	Condensor motor	2002	1,162		5				55
56	Compressor	2002	515		10				56
57	Fire protection	2002	1,811		7				57
58	Pump system	2002	1,805		10				58
59	Fire protection	2003	1,811		7				59
60	Fire protection	2003	1,811		7				60
61	Circulating pump	2003	1,401		10				61
62	Fire protection	2003	1,811		7				62
63	Air station	2003	1,897		10				63
64	Fire protection	2003	1,884		7				64
65	Data wiring	2003	804		10				65
66	Hot water circulation pump	2003	860		10				66
67	Fire alarm system power supply	2003	1,433		10				67
68	Boiler tubes	2003	7,312		10				68
69	Pump rayback boiler	2003	1,109		10				69
70	TOTAL (lines 4 thru 69)		\$ 4,496,439	\$		\$	\$	\$	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 Benedict Nursing &amp; Rehab

# 0044784

Report Period Beginning:

7/1/2007

Ending:

6/30/2008

## 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>		\$ 4,496,439	\$		\$	\$	\$	1
2	AO Smith 40 gallon	2003	638		10				2
3	Century high ambient motor	2003	781		5				3
4	Boiler repairs	2003	808		10				4
5	Fire protection	2003	2,161		7				5
6	Air compressor	2003	695		5				6
7	Side stream filter system	2003	4,575		10				7
8	Tamper re-wiring	2004	1,296		10				8
9	Air pump handler	2004	1,069		10				9
10	Fire protection	2004	2,161		7				10
11	Exhaust fan	2004	1,158		10				11
12	Fire protection	2004	2,161		7				12
13	Wiring & cabling	2004	641		10				13
14									14
15	Landscaping additions, tree removal, new trees, etc.	2005	8,500		5-15				15
16	Concrete sidewalk	2005	3,600		12				16
17	Reseal & restripe parking lot	2005	6,910						17
18	Roof replacement	2005	104,735		15				18
19	Repair & update east elevator	2005	3,187		10				19
20	Refractory for boiler	2005	3,765		10				20
21	Fire-safe shutoff valve	2005	1,310		8				21
22	Care-watch system	2005	2,075		5				22
23	Von Duprin controls wiring	2005	1,800		8				23
24	Install egress exits systems on 2nd floor	2005	14,540		15				24
25	Carpet	2005	11,946		5				25
26	One-man Genie gated lift	2005	7,565		15				26
27	Fire equipment	2005	1,027		15				27
28	Repair & replace pumps	2005	19,495		15				28
29									29
30	Replace limestone on sign	2006	1,800		15				30
31	Replace valve & actuator, repipe bad piping	2006	2,032		15				31
32	Carpet	2006	12,624		10				32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 4,721,494	\$		\$	\$	\$	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 Benedict Nursing &amp; Rehab

# 0044784

Report Period Beginning:

7/1/2007

Ending:

6/30/2008

## 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>		\$ 4,721,494	\$		\$	\$	\$	1
2	Replace 4" check valve on sump pump	2006	1,674		8				2
3	Replace power supply for main fire alarm system	2006	3,645		10				3
4	Repair/Replace waste stack for kitchen sink	2006	1,688		10				4
5	Carpeting for resident rooms	2006	10,890		10				5
6	2" x 3/4" pipe replacement	2006	3,645		15				6
7	Carpeting for Chapel	2006	3,184		10				7
8	Lowering of Tabernacle	2006	288		5				8
9									9
10	Cable wiring activities	2006	2,228	74	15	74		148	10
11	Install cable 1st & 2nd floor nurse station	2006	5,791	193	15	193		386	11
12	Carpet for apartments	2006	10,495	749	7	749		1,498	12
13	Chair	2006	14,946	498	15	498		996	13
14	Carpet for dining room	2006	9,947	711	7	711		1,422	14
15	Washer	2006	1,708	122	7	122		244	15
16	Carpet for chapel	2006	1,997	143	7	143		286	16
17	Analog station module, cable	2006	1,376	86	8	86		172	17
18	Platinum 5 LX oxygen concentrator	2006	6,385	456	7	456		912	18
19	Alternating pressure pad suntech	2006	8,550	610	7	610		1,220	19
20	Custom bedside wood edge, dresser	2007	4,613	308	15	308		462	20
21	All purpose riser bed	2007	13,331	1,334	10	1,334		2,001	21
22	Install new cooling coil	2006	16,195	1,025	7	1,025		2,050	22
23	Install new heater for dish machine	2006	2,138	153	7	153		306	23
24	Test and certify Model 709 fire	2006	1,770	126	7	126		252	24
25	Remove and install new 200 gal storage tank	2007	11,345	1,620	7	1,620		2,430	25
26	55-60 lb. Washer	2007	16,780	2,098	8	2,098		3,147	26
27	Clean out cracked sealer around roof	2007	2,115	264	8	264		396	27
28	Sofa & loveseat	2007	2,103	140	15	140		210	28
29	Roof shingles	2007	1,950	196	10	196		294	29
30	Ejector pump in boiler room	2007	5,664	708	8	708		1,062	30
31	Engineering services	2007	2,259	322	7	322		483	31
32	Install new gasketed fresh air damper for kitchen	2006	4,611	329	7	329		658	32
33	Single deck convection oven	2007	8,798	1,100	8	1,100		1,650	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 4,903,603	\$ 13,365		\$ 13,365	\$	\$ 22,685	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 12C, Carried Forward		\$ 4,903,603	\$ 13,365		\$ 13,365	\$	\$ 22,685	1
2	Fire alarm door system upgrrade	2007	1526	76		76		76	2
3	Fire alarm door system upgrrade	2008	29,855	1,493		1,493		1,493	3
4	Install 3 phones in Elevator	2007	4,650	233		233		233	4
5	New motor for East Elevator	2008	9,047	452		452		452	5
6	Upgrade to boiler system	2007	11,408	908		908		908	6
7	Upgrade to boiler system	2008	15,778	718		718		718	7
8	Exhaust Mods, Permits, Bonds, Drawings	2007	16,092	1,609		1,609		1,609	8
9	Repair Injector pump	2007	8,305	277		277		277	9
10	Installation of Jeron EC-210 Duty Station	2008	2,650	133		133		133	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	Financial statement depreciation			164,479		164,479		1,307,402	32
33	Allocated from Home Office					64,511	64,511		33
34	TOTAL (lines 1 thru 33)		\$ 5,002,914	\$ 183,743		\$ 248,254	\$ 64,511	\$ 1,335,986	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	\$ 742,110	\$ 9,482	\$ 9,482	\$	5 to 10	\$ 658,172	71
72	Current Year Purchases	96,743	5,072	5,072	0	5 to 20	5,072	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 838,853	\$ 14,554	\$ 14,554	\$ 0		\$ 663,244	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	N/A			\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 8,998,957	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 198,297	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 262,808	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 64,511	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,999,230	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	Depreciable non-care assets	\$ 1,095,075	\$ 45,675	\$ 449,986	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 1,095,075	\$ 45,675	\$ 449,986	91

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

**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:				\$ _____		N/A	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: \$ 3,032 Description: Medical Equipment - \$3,032

(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			_____	N/A	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	10A(1,3)	959 hrs	\$ 38,896	459	\$ 30,022		1,418	\$ 68,918	1
2	Licensed Speech and Language Development Therapist	10A(1,3)	36 hrs	1,231	62	4,039		98	5,270	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(1,2,3)	2592 hrs	105,587	1,810	95,477	5,255	4,402	206,319	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				709,950		709,950	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>			\$ 145,714	2,331	\$ 129,538	\$ 715,205	5,918	\$ 990,457	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 Benedict Nursing &amp; Rehab

# 0044784

Report Period Beginning: 7/1/2007

Ending:

6/30/2008

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/2008

(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	\$ 599,654	\$ 599,654	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 215,504 )	612,836	612,836	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments	40,226	40,226	5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	4,404	4,404	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>	\$ 1,257,120	\$ 1,257,120	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	5,138,097	5,138,097	12
13	Land	3,158,120	3,157,190	13
14	Buildings, at Historical Cost	5,684,494	4,287,083	14
15	Leasehold Improvements, at Historical Cost	45,375	715,831	15
16	Equipment, at Historical Cost	1,273,924	838,853	16
17	Accumulated Depreciation (book methods)	(2,390,113)	(1,999,230)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	61,140	61,140	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(59,102)	(59,102)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify): <b>Noncare Assets(Net)</b>		645,089	22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 12,911,935	\$ 12,784,951	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 14,169,055	\$ 14,042,071	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 102,666	\$ 102,666	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	<b>Due to Related Parties</b>	212,441	212,441	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 315,107	\$ 315,107	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>	\$ 315,107	\$ 315,107	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 13,853,948	\$ 13,726,964	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 14,169,055	\$ 14,042,071	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>12,286,342</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Prior Period adjustments</b>	<b>427,861</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>12,714,203</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>1,139,745</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>1,139,745</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>13,853,948</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	\$ 8,682,448	1
2	Discounts and Allowances for all Levels	(1,766,873)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 6,915,575	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,249,322	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 1,249,322	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	6,661	14
15	Telephone, Television and Radio	2,430	15
16	Rental of Facility Space	29,716	16
17	Sale of Drugs	839,165	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	7,406	19
20	Radiology and X-Ray		20
21	Other Medical Services	246,843	21
22	Laundry	27,136	22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 1,159,357	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	236,368	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 236,368	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a	<u>See Schedule 19A</u>	39,138	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 39,138	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 9,599,760	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	1,652,292	31
32	Health Care	3,229,836	32
33	General Administration	2,446,746	33
	<b>B. Capital Expense</b>		
34	Ownership	256,248	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	820,542	35
36	Provider Participation Fee	54,351	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 8,460,015	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	1,139,745	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 1,139,745	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. Benedict Nursing & Rehabilitation Center**  
**Provider # 0044784**  
**7/1/2007 - 6/30/2008**

**Schedule 19A**

XVII - Income Statement: Line 22 - Laundry

**NOTE:** Laundry revenue is generated from charges to private pay residents located in the facility, therefore it has not been offset against related expenses.

Line 28: Other Revenue

Description	
ADMI - OTHER REVENUE	35,869
CHAR - OTHER	2,836
ENVI - CLEANING SUPP	433
Total	<u>39,138</u>

**SEE ACCOUNTANTS' COMPILATION REPORT**

Facility Name & ID Number **St Benedict Nursing & Rehab**

# **0044784**

Report Period Beginning:

**7/1/2007**

Ending:

**6/30/2008**

**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	1,960	2,080	\$ 81,236	\$ 39.06	1
2	Assistant Director of Nursing					2
3	Registered Nurses	18,919	21,211	711,203	33.53	3
4	Licensed Practical Nurses	8,855	9,987	275,456	27.58	4
5	CNAs & Orderlies	75,304	84,352	1,141,311	13.53	5
6	CNA Trainees					6
7	Licensed Therapist	3,234	3,587	145,714	40.62	7
8	Rehab/Therapy Aides	3,090	3,311	62,305	18.82	8
9	Activity Director	1,864	2,032	51,717	25.45	9
10	Activity Assistants	10,836	11,666	197,412	16.92	10
11	Social Service Workers	4,423	4,833	112,713	23.32	11
12	Dietician	768	880	30,062	34.16	12
13	Food Service Supervisor	1,697	2,158	65,309	30.26	13
14	Head Cook	8,652	9,699	131,416	13.55	14
15	Cook Helpers/Assistants	19,361	21,929	218,911	9.98	15
16	Dishwashers					16
17	Maintenance Workers	5,111	5,762	121,973	21.17	17
18	Housekeepers	14,088	16,346	162,366	9.93	18
19	Laundry	9,886	11,251	114,827	10.21	19
20	Administrator	916	1,040	62,819	60.40	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,649	8,581	141,326	16.47	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: MDS Coordinator	2,124	2,462	84,317	34.25	32
33	Other(specify) <u>Assisted Living</u>	7,639	8,621	94,926	11.01	33
34	TOTAL (lines 1 - 33)	206,376	231,788	\$ 4,007,319 *	\$ 17.29	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	18,060	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	48	2,640	12(3)	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	48	\$ 20,700		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	420	\$ 21,274	10(3)	50
51	Licensed Practical Nurses	107	4,670	10(3)	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	527	\$ 25,944		53

SEE ACCOUNTANTS' COMPILATION REPORT



**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>		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Benedict Nursing & Rehab# 0044784Report Period Beginning: 7/1/2007Ending: 6/30/2008**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? Yes  
If YES, give association name and amount. LSN, \$2625, ICLTC \$6663
- (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? 12.5 yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 12,841 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. \$ 54,351  
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.

**SEE ACCOUNTANTS' COMPILATION REPORT**

- (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. \$ 6,661
- (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? Adequate records have been maintained.
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? 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