

Facility Name & ID Number St Francis Nursing & Rehab Center

0044370 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	<u>124</u>	Skilled (SNF)	<u>124</u>	<u>45,384</u>	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	<u>124</u>	TOTALS	<u>124</u>	<u>45,384</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>7,055</u>	<u>810</u>	<u>10,066</u>	<u>17,931</u>	8
9	SNF/PED					9
10	ICF	<u>17,081</u>	<u>2,866</u>	<u>94</u>	<u>20,041</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>24,136</u>	<u>3,676</u>	<u>10,160</u>	<u>37,972</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.67%

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

N/A (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 03/08/85

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

YES Date 03/08/85 NO

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

YES NO If YES, enter number of beds certified 78 and days of care provided 8,585

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

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

Facility Name & ID Number St Francis Nursing & Rehab Center # 0044370 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
	A. General Services										
1	Dietary	353,164	42,236	661	396,061		396,061		396,061		1
2	Food Purchase		241,399		241,399		241,399	(6,035)	235,364		2
3	Housekeeping	177,014	29,320	3,663	209,997		209,997		209,997		3
4	Laundry	654	214,785		215,439		215,439		215,439		4
5	Heat and Other Utilities			141,572	141,572		141,572		141,572		5
6	Maintenance	54,794	10,927	97,855	163,576		163,576		163,576		6
7	Other (specify):*										7
8	TOTAL General Services	585,626	538,667	243,751	1,368,044		1,368,044	(6,035)	1,362,009		8
	B. Health Care and Programs										
9	Medical Director			26,328	26,328		26,328		26,328		9
10	Nursing and Medical Records	2,502,118	140,936	43,755	2,686,809		2,686,809		2,686,809		10
10a	Therapy	240,981	1,861	94,922	337,764		337,764		337,764		10a
11	Activities	135,800	14,934	17,696	168,430		168,430		168,430		11
12	Social Services	54,571	618	560	55,749		55,749		55,749		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,933,470	158,349	183,261	3,275,080		3,275,080		3,275,080		16
	C. General Administration										
17	Administrative	116,986		478,025	595,011		595,011	(478,025)	116,986		17
18	Directors Fees										18
19	Professional Services			750	750		750		750		19
20	Dues, Fees, Subscriptions & Promotions			25,509	25,509		25,509		25,509		20
21	Clerical & General Office Expenses	176,266	28,459	22,853	227,578		227,578	525,824	753,402		21
22	Employee Benefits & Payroll Taxes			1,174,141	1,174,141		1,174,141	167,589	1,341,730		22
23	Inservice Training & Education										23
24	Travel and Seminar			6,243	6,243		6,243		6,243		24
25	Other Admin. Staff Transportation			16,698	16,698		16,698		16,698		25
26	Insurance-Prop.Liab.Malpractice			197,165	197,165		197,165		197,165		26
27	Other (specify):*										27
28	TOTAL General Administration	293,252	28,459	1,921,384	2,243,095		2,243,095	215,388	2,458,483		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,812,348	725,475	2,348,396	6,886,219		6,886,219	209,353	7,095,572		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number

St Francis Nursing & Rehab Center

#0044370

Report Period Beginning:

07/01/2007

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	
	D. Ownership											
30	Depreciation			354,818	354,818		354,818	62,988	417,806			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							11,560	11,560			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			60,180	60,180		60,180		60,180			35
36	Other (specify):*											36
37	TOTAL Ownership			414,998	414,998		414,998	74,548	489,546			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		928,992		928,992		928,992		928,992			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			68,076	68,076		68,076		68,076			42
43	Other (specify):* nonallowable costs			4,401	4,401		4,401	(4,401)				43
44	TOTAL Special Cost Centers		928,992	72,477	1,001,469		1,001,469	(4,401)	997,068			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,812,348	1,654,467	2,835,871	8,302,686		8,302,686	279,500	8,582,186			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	(6,035)	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	(4,401)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule <u>See Pg 5A</u>				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (10,436)		\$	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)	289,936		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 289,936		36
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 279,500		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	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY							
48		49		50		51	
						52	

St Francis Nursing & Rehab Center

ID# 0044370

Report Period Beginning: 07/01/2007

Ending: 06/30/2008

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

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

07/01/2007

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	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(6,035)	0	0	0	0	0	0	0	0	0	0	(6,035)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(6,035)	0	0	0	0	0	0	0	0	0	0	(6,035)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(478,025)	0	0	0	0	0	0	0	0	0	(478,025)	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	525,824	0	0	0	0	0	0	0	0	0	525,824	21
22	Employee Benefits & Payroll Taxes	0	167,589	0	0	0	0	0	0	0	0	0	167,589	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	0	215,388	0	215,388	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(6,035)	215,388	0	209,353	29								

STATE OF ILLINOIS

Summary B

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

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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	0	62,988	0	0	0	0	0	0	0	0	0	62,988	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	11,560	0	0	0	0	0	0	0	0	0	11,560	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	0	74,548	0	74,548	37								
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(4,401)	0	0	0	0	0	0	0	0	0	0	(4,401)	43
44	TOTAL Special Cost Centers	(4,401)	0	0	0	0	0	0	0	0	0	0	(4,401)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(10,436)	289,936	0	279,500	45								

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	21 Clerical & data processing	\$	Resurrection Health Care	100.00%	\$ 525,824	\$ 525,824	1
2	V	22 Employee benefits		Resurrection Health Care	100.00%	167,589	167,589	2
3	V	30 Depreciation		Resurrection Health Care	100.00%	62,988	62,988	3
4	V	32 Interest		Resurrection Health Care	100.00%	11,560	11,560	4
5	V							5
6	V							6
7	V	17 Intercompany Expense	478,025	Resurrection Health Care	100.00%		(478,025)	7
8	V	39 Intercompany Pharmacy	928,992	Resurrection Health Care	100.00%	928,992		8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,407,017			\$ 1,696,953	\$ * 289,936	14

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

Facility Name & ID Number St Francis Nursing & Rehab Center # 0044370 Report Period Beginning: 07/01/2007 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									\$		1
2											2
3	See Attached Schedule 7A										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 Francis Nursing & Rehab Center

0044370 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 W. Talcott
 City / State / Zip Code Chicago, IL 60631
 Phone Number (773) 774-8000
 Fax Number (773) 594-7488

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	21	Clerical & data processing			\$	\$		\$ 525,824	1
2	22	Employee benefits						167,589	2
3	30	Depreciation						62,988	3
4	32	Interest						11,560	4
5									5
6									6
7									7
8	39	Intercompany Pharmacy						928,992	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				\$	\$		\$ 1,696,953	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

St Francis Nursing & Rehab Center

0044370

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			
	A. Directly Facility Related																	
	Long-Term																	
1							\$	\$				\$						
2																		
3																		
4																		
5																		
	Working Capital																	
6																		
7																		
8																		
9	TOTAL Facility Related						\$	\$				\$						
	B. Non-Facility Related*																	
10																		
11									Allocated from Home Office			11,560						
12																		
13																		
14	TOTAL Non-Facility Related						\$	\$				\$ 11,560						
15	TOTALS (line 9+line14)						\$	\$				\$ 11,560						

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.)		\$	2007	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	
Facility is a not-for-profit and does not pay real estate tax.				
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

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 Francis Nursing & Rehab Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0044370

CONTACT PERSON REGARDING THIS REPORT Thomas W. Groenwald

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 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>Facility is a not-for-profit and does not pay real estate tax.</u>	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES 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 Francis Nursing & Rehab Center

0044370

Report Period Beginning:

07/01/2007 Ending:

06/30/2008

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 51,712 B. General Construction Type: Exterior Brick Frame _____ Number of Stories Three

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).

NONE

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

1. Total Amount Incurred: _____ 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>Resident Care</u>		<u>1985</u>	<u>\$ 188,421</u>	<u>1</u>
2					<u>2</u>
3	TOTALS			\$ 188,421	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Francis Nursing & Rehab Center

0044370

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	124	1985	1961	\$ 2,426,118	\$ 80,660	30	\$ 80,660	\$	\$ 1,901,833	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	General Construction/Renovation		1986	12,875		12			12,875	9
10	General Construction/Renovation		1986	3,543		10			3,543	10
11	General Construction/Renovation		1986	82,489		15			82,489	11
12	General Construction/Renovation		1986	44,717		20			44,717	12
13	General Construction/Renovation		1987	5,529		12			5,529	13
14	General Construction/Renovation		1987	2,560		10			2,560	14
15	Inhouse Labor		1988	7,688		5			7,688	15
16	Shower		1989	3,836	192	20	192		3,741	16
17	Lobby Refurbish/Exterior Renovation		1991	73,428		5			73,428	17
18	Dishwasher and Installation		1991	7,332		10			7,332	18
19	Sidewalk Replacement		1991	4,880		5			4,880	19
20	Remodel		1993	30,862	1,031	15	1,031		30,862	20
21	Vestibule: Wallpaper/Painting; Window Draperies		1996	4,601	307	15	307		3,682	21
22	Combustion Air Handling System		1996	24,969		10			24,969	22
23	Fire Alarm System		1996	71,668		10			71,668	23
24	Parking Lot Repaving		1997	7,162	477	15	477		5,270	24
25	Roofing: Drain flashing collar;coping replacement									25
26	deck repair; masonry repointing; install new drains		1997	74,400	4,960	15	4,960		54,767	26
27	Admin offices: carpeting; wallpapering & painting;									27
28	electrical wiring and lighting		1997	12,270	818	15	818		9,032	28
29	Renovate 3 Nursing Floors: painting & wallpapering;									29
30	install ADA handles & mirrors; carpeting & floor									30
31	tiling; installation of glass blocks & window									31
32	masonry; installation and modification of light									32
33	fixtures; plumbing & H.V.A.C. sprinklers		1997	499,653	33,310	15	33,310		367,799	33
34	Security Camera System		1997	16,014		10			16,014	34
35	Parking Lot Repaving		1999	8,530	569	15	569		5,404	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

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	Day Room Expansion & Renovation: tear down wall		\$	\$		\$	\$	\$	37
38	between day room & conference room to expand day								38
39	room; install new ceiling & ceiling tiles; new flooring;								39
40	wallpaper & painting; install cupboard & sink; revamp								40
41	closet; window treatment	1999	23,212	2,263	10	2,263		21,498	41
42	Remove & replace all windows on 1st, 2nd, & 3rd floors	1999	118,907	7,927	15	7,927		75,307	42
43	Acquisition and installation of sternberg lights	2000	7,400	493	15	493		4,192	43
44	Fire dampers/automatic closers	2000	21,493	1,433	15	1,433		12,180	44
45	Vonsuperior Panic Hardware for 9 doors	2000	8,058		7			8,058	45
46	Demolition of existing entrance, waiting area and								46
47	chapel entrance; install flooring, automatic door system,								47
48	anodized store front thermal glazed window system,								48
49	ceiling tile system w/lighting, and wall covering;								49
50	relocate chapel entrance; new concrete sidewalks								50
51	and accessibility ramp.	2000	190,424	19,042	10	19,042		161,859	51
52	Relocate portable fire extinguishers with casing &								52
53	vinyl wallcovering	2001	4,606		5			4,606	53
54	Acquisition/installation exterior concrete bench	2001	2,674		5			2,674	54
55	Acquisition/installation 54"X114" plate glass								55
56	for dayroom	2001	1,350	96	7	96		1,350	56
57	Refinish & apply slip grips 36 bathtubs	2001	9,720		5			9,720	57
58	PT/OT renovation: demolition of 2 block walls, casework								58
59	and flooring; install new cabinets; new folding partition;								59
60	new drywall partition; new VCT flooring; paint and vinyl								60
61	wallcovering; plumbing for sinks 7 sprinklers	2001	56,042	5,604	10	5,604		42,031	61
62	Parking lot expansion	2002	536,437	34,878	15	34,878		226,726	62
63	Elevator alarm system	2002	30,000	4,286	7	4,286		27,858	63
64	Building security system	2002	21,710	3,101	7	3,101		20,158	64
65	Solar shades/awning & installation	2002	5,084	708	7	708		4,603	65
66	Window air conditioners & installation	2002	10,439		5			10,439	66
67	IDPH safety code compliance - includes but not limited to:								67
68	protection of lay-in fixtures and equipment;								68
69	automatic door closures tied into fire alarm system which (continued on P12B)								69
70	TOTAL (lines 4 thru 69)		\$ 4,472,680	\$ 202,155		\$ 202,155	\$	\$ 3,373,341	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 4,472,680	\$ 202,155		\$ 202,155	\$	\$ 3,373,341	1
2	is activated by smoke detectors, pull stations and sprinkler								2
3	system; installation of smoke operated fire dampers and								3
4	access panels in exhaust duct system penetrating smoke								4
5	barrier walls located on floors 1, 2 and 3.	2002	481,852	46,597	10	46,597		302,880	5
6	Interior renovation - includes but not limited to:								6
7	Toli floor and ramp; carpet administration area; switch-								7
8	bank for lobby and entrance area; new light fixtures in								8
9	various area; replace piping to boilers; new condensing								9
10	unit to north window well; reheat coil in lobby; replace								10
11	bathroom fixtures; replace/upgrade ceiling in various areas;								11
12	various wall modifications; replace various bathroom								12
13	fixtures; various other electrical and plumbing								13
14	modifications.	2002	159,709	16,549	10	16,549		107,570	14
15	Exterior renovation - includes not limited to: sliding doors;								15
16	removal and replacement of concrete curbs; paving,								16
17	grading and stonework; install new fire ceiling and framing								17
18	in smoking area; new handicap signs; various electrical								18
19	work in outside waiting area (includes new heaters,								19
20	intercom and doorbell).	2002	98,000	6,533	15	6,533		42,465	20
21	Lobby renovation - includes but not limited to: selective								21
22	demolition of existing lobby, toilet room, and reception								22
23	and replacement of each as well as new assisted bathing.								23
24	this includes new partitions, electric plumbing, HVAC,								24
25	acoustic panel ceiling, floor finishes, doors, frames,								25
26	interior windows and casement. Floral fixtures and								26
27	artwork.	2002	166,549	11,732	14	11,732		76,259	27
28	Acquisition/installation of medical records voice and data								28
29	cables, 24-port patch panel, and fire stop & sleeves	2003	4,646	310	15	310		1,705	29
30	2 sewage pumps	2003	5,752	383	15	383		2,107	30
31	Down light style fixtures-acquisition and electrical work	2003	3,780	252	15	252		1,386	31
32	Elevator control valve piping	2003	10,037	1,004	10	1,004		5,522	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,403,005	\$ 285,515		\$ 285,515	\$	\$ 3,913,235	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 5,403,005	\$ 285,515		\$ 285,515	\$	\$ 3,913,235	1
2	Remove existing and install new nurse station (1st floor)	2004	8,300	553	15	553		2,469	2
3	Purchase & install quarry tile in kitchen entrance	2004	1,114	223	5	223		1,003	3
4	Grout kitchen floor	2004	4,740	474	10	474		2,133	4
5	Purchase & install raised round rubber tiles in elevator	2004	1,538	308	5	308		1,386	5
6	Purchase & install 2 ceiling 40-gallon ASME coded								6
7	expansion tanks	2004	3,685	737	5	737		3,317	7
8	Purchase & install hot water heater	2004	3,250	216	15	216		972	8
9	Purchase & install category 5E wire cable in elevator	2004	758	76	10	76		342	9
10	Replace wood floor with concrete in oxygen storage closet	2004	1,750	116	15	116		522	10
11									11
12	Carpet for lobby and chapel	2005	4,730	955	5	955		1,350	12
13	Overhead domestic water line	2005	1,075	108	10	108		153	13
14	Replace main drain & rod sewer	2005	3,052	203	15	203		288	14
15	Elevator upgrade	2005	6,184	618	10	618		873	15
16	Lever drains in three compartment sinks	2005	1,744	174	10	174		244	16
17	Baxtor Flo Guard Pump	2005	5,973	597	10	597		997	17
18									18
19	Phase 2 Fireman's Recall	2006	59,921	3,995	15	3,995		9,812	19
20	Upgrade electrical feed for reznor roof top unit	2006	12,950	1,295	10	1,295		3,238	20
21	Replace sprinkler heads in kitchen	2006	2,137	214	10	214		535	21
22	Replace ceiling tiles in kitchen	2006	2,300	153	15	153		383	22
23	Mixer bench gear drive 20qt.	2006	3,820	255	15	255		637	23
24	Vulcan Range 60" burner 20" griddle gas type	2006	3,945	395	10	395		987	24
25	Replace window & glaze	2006	4,765	318	15	318		795	25
26	Combination Lennox make up air unit	2006	15,000	1,500	10	1,500		3,750	26
27	50 pair cable to north & south wings	2006	4,617	308	15	308		770	27
28	Relays, transformers & t-stats on boiler	2006	2,500	250	10	250		625	28
29	Elevator upgrade	2006	14,625	1,462	10	1,462		3,655	29
30									30
31	Replace Concrete	2006	7,100	473	15	473		710	31
32	Furnish & Install Fire Rated Wood Doors	2006	2,741	182	15	182		273	32
33	Furnish & Install New Door in Receiving Area	2006	4,230	202	15	202		343	33
34	TOTAL (lines 1 thru 33)		\$ 5,591,549	\$ 301,875		\$ 301,875	\$	\$ 3,955,797	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 5,591,549	\$ 301,875		\$ 301,875	\$	\$ 3,955,797	1
2	Inspect & Install 3 Fire Dampers & 3 Access Panels	2006	5,049	505	10	505		757	2
3	Remove & Replace tile around sink & paint ceiling in rooms 303 &	2007	3,958	440	8-10	440		660	3
4	Install 6" RPZ valve on fire sprinkler system	2006	7,000	700	10	700		1,050	4
5	Replace Sprinkler Heads on Floors 1, 2 & 3	2007	3,439	491	7	491		737	5
6	Replace voice cable on 3rd Floor	2007	14,994	2,142	7	2,142		3,213	6
7	35 American Standard - Madera	2007	6,475	926	7	926		1,389	7
8	Electrical work	2007	6,885	861	8	861		1,291	8
9	Ceiling Tile Toilet Repair Kits	2007	12,400	1,550	8	1,550		2,325	9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29	Allocated from Home Office					62,988	62,988		29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,651,749	\$ 309,490		\$ 372,478	\$ 62,988	\$ 3,967,219	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	\$ 840,881	\$ 38,695	\$ 38,695	\$	5-15	\$ 639,668	71
72	Current Year Purchases	147,191	6,633	6,633		5-10	6,633	72
73	Fully Depreciated Assets	816,547					816,547	73
74								74
75	TOTALS	\$ 1,804,619	\$ 45,328	\$ 45,328	\$		\$ 1,462,848	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)	\$ 7,644,789	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 354,818	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 417,806	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 62,988	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 5,430,067	85

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

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

G. Construction-in-Progress

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

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

** This must agree with Schedule V line 30, column 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:				\$			3
4	Additions							4
5					N/A			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: \$ 60,180 Description: Copier/Printers - 4565; Therapeutic Equip - 21395; Special Beds - 34220

(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			N/A		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 the the facility policy to hire only Certified Nursing 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>
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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	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	10A(1,2,3)	2911	hrs	\$ 110,481	725	\$ 43,518	\$ 853	3,636	\$ 154,852	1
2	Licensed Speech and Language Development Therapist	10A(1,2,3)	154	hrs	5,829	38	2,296	45	192	8,170	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10A(1,2,3)	3285	hrs	124,671	818	49,108	963	4,103	174,742	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 prescrpts				928,992		928,992	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	TOTAL				\$ 240,981	1,581	\$ 94,922	\$ 930,853	7,931	\$ 1,266,756	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 & ID Number St Francis Nursing & Rehab Center

0044370

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*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 69,900	\$ 69,900	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 516,253)	1,080,980	1,080,980	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	7,165	7,165	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Exchange Account	508,236	508,236	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,666,281	\$ 1,666,281	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		188,421	13
14	Buildings, at Historical Cost	4,625,290	2,426,118	14
15	Leasehold Improvements, at Historical Cost	454,718	3,225,631	15
16	Equipment, at Historical Cost	2,376,387	1,804,619	16
17	Accumulated Depreciation (book methods)	(5,416,175)	(5,430,067)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,040,220	\$ 2,214,722	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,706,501	\$ 3,881,003	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 106,163	\$ 106,163	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due From Related Entities	10,002,068	10,002,068	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 10,108,231	\$ 10,108,231	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 10,108,231	\$ 10,108,231	46
47	TOTAL EQUITY(page 18, line 24)	\$ (6,401,730)	\$ (6,227,228)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,706,501	\$ 3,881,003	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (5,960,161)	1
2	Restatements (describe):		2
3	Prior Period Adjustment	455,429	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (5,504,732)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(896,998)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (896,998)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (6,401,730)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached. Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

1

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 8,514,278	1
2	Discounts and Allowances for all Levels	(3,558,112)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,956,166	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	980,834	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 980,834	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	6,035	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,099,381	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	328,155	21
22	Laundry	34,695	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,468,266	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Other Revenue</u>	422	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 422	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,405,688	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,368,044	31
32	Health Care	3,275,080	32
33	General Administration	2,243,095	33
	B. Capital Expense		
34	Ownership	414,998	34
	C. Ancillary Expense		
35	Special Cost Centers	933,393	35
36	Provider Participation Fee	68,076	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,302,686	40
41	Income before Income Taxes (line 30 minus line 40)**	(896,998)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (896,998)	43

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

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

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

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

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

0044370

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

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	1,392	1,553	\$ 62,833	\$ 40.46	1
2	Assistant Director of Nursing					2
3	Registered Nurses	26,881	30,361	1,115,968	36.76	3
4	Licensed Practical Nurses	8,648	9,838	259,985	26.43	4
5	CNAs & Orderlies	59,490	66,695	874,568	13.11	5
6	CNA Trainees					6
7	Licensed Therapist	5,446	6,434	240,981	37.45	7
8	Rehab/Therapy Aides	5,948	6,430	88,843	13.82	8
9	Activity Director	1,704	2,032	39,300	19.34	9
10	Activity Assistants	3,639	4,080	42,436	10.40	10
11	Social Service Workers	1,880	2,032	54,571	26.86	11
12	Dietician					12
13	Food Service Supervisor	3,881	4,517	97,527	21.59	13
14	Head Cook	7,701	8,755	119,360	13.63	14
15	Cook Helpers/Assistants	11,113	12,823	136,277	10.63	15
16	Dishwashers					16
17	Maintenance Workers	2,122	2,321	54,794	23.61	17
18	Housekeepers	14,213	15,810	177,014	11.20	18
19	Laundry	48	48	654	13.63	19
20	Administrator	2,000	2,348	116,986	49.82	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,210	10,231	176,266	17.23	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: Care Plan Coord	2,471	2,941	99,921	33.98	32
33	Other(specify) <u>Religious Wages</u>	1,311	1,556	54,064	34.75	33
34	TOTAL (lines 1 - 33)	169,098	190,805	\$ 3,812,348 *	\$ 19.98	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 26,328	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)	\$ 26,328		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	380 13,471	10(3)	51
52	Certified Nurse Assistants/Aides	681 15,191	10(3)	52
53	TOTAL (lines 50 - 52)	1,061 \$ 28,662		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	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Francis Nursing & Rehab Center# 0044370Report 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? Yes
If YES, give association name and amount. LSNI/AAHSA - 2625; ICLTC - 5853
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 7.5 yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 10,500 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. \$ 68,076
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? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 6,035
- (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? Yes
Firm Name: KPMG LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Audit not yet 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