

Facility Name & ID Number Villa Scalabrini Nursing & Rehab

0044792 Report Period Beginning: 07/01/07 Ending: 06/30/08

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 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	164	Skilled (SNF)	164	60,024	1
2		Skilled Pediatric (SNF/PED)			2
3	82	Intermediate (ICF)	82	30,012	3
4		Intermediate/DD			4
5	7	Sheltered Care (SC)	7	2,562	5
6		ICF/DD 16 or Less			6
7	253	TOTALS	253	92,598	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	19,971	2,660	19,913	42,544	8
9	SNF/PED					9
10	ICF	24,721	16,269	878	41,868	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	44,692	18,929	20,791	84,412	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.16%

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

None (Do not include bed-hold days in Section B.)

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

None

F. Does the facility maintain a daily midnight census?

Yes

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

YES NO

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

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

YES NO

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

Date started 03/01/2000

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

YES Date 03/01/00 NO

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

YES NO If YES, enter number of beds certified 154 and days of care provided 18,743

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 Villa Scalabrini Nursing & Rehab # 0044792 Report Period Beginning: 07/01/07 Ending: 06/30/08

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	556,732	76,038	1,680	634,450		634,450		634,450		1
2	Food Purchase		480,111		480,111		480,111	(10,673)	469,438		2
3	Housekeeping	263,401	57,624		321,025		321,025		321,025		3
4	Laundry	161,949	57,165		219,114		219,114		219,114		4
5	Heat and Other Utilities			405,632	405,632		405,632		405,632		5
6	Maintenance	157,722	996	349,252	507,970		507,970		507,970		6
7	Other (specify):*										7
8	TOTAL General Services	1,139,804	671,934	756,564	2,568,302		2,568,302	(10,673)	2,557,629		8
	B. Health Care and Programs										
9	Medical Director			14,000	14,000		14,000		14,000		9
10	Nursing and Medical Records	5,474,784	320,773	55,561	5,851,118		5,851,118		5,851,118		10
10a	Therapy	258,441	20,694	77,792	356,927		356,927		356,927		10a
11	Activities	188,912	16,927	1,959	207,798		207,798		207,798		11
12	Social Services	27,085			27,085		27,085		27,085		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	5,949,222	358,394	149,312	6,456,928		6,456,928		6,456,928		16
	C. General Administration										
17	Administrative	66,971		1,070,441	1,137,412		1,137,412	(1,070,441)	66,971		17
18	Directors Fees										18
19	Professional Services										19
20	Dues, Fees, Subscriptions & Promotions			10,615	10,615		10,615		10,615		20
21	Clerical & General Office Expenses	417,216	70,973	19,802	507,991		507,991	998,963	1,506,954		21
22	Employee Benefits & Payroll Taxes			2,522,519	2,522,519		2,522,519	325,827	2,848,346		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,816	1,816		1,816		1,816		24
25	Other Admin. Staff Transportation			6,131	6,131		6,131		6,131		25
26	Insurance-Prop.Liab.Malpractice			190,831	190,831		190,831		190,831		26
27	Other (specify):*										27
28	TOTAL General Administration	484,187	70,973	3,822,155	4,377,315		4,377,315	254,349	4,631,664		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	7,573,213	1,101,301	4,728,031	13,402,545		13,402,545	243,676	13,646,221		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

Villa Scalabrini Nursing & Rehab

#0044792

Report Period Beginning:

07/01/07

Ending:

06/30/08

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			491,346	491,346		491,346	82,529	573,875			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							17,905	17,905			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			34,426	34,426		34,426		34,426			35
36	Other (specify):*											36
37	TOTAL Ownership			525,772	525,772		525,772	100,434	626,206			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,681,847		1,681,847		1,681,847		1,681,847			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			130,794	130,794		130,794		130,794			42
43	Other (specify):*			2,321	2,321		2,321	(2,321)				43
44	TOTAL Special Cost Centers		1,681,847	133,115	1,814,962		1,814,962	(2,321)	1,812,641			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	7,573,213	2,783,148	5,386,918	15,743,279		15,743,279	341,789	16,085,068			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	(10,673)	2		4
5	Telephone, TV & Radio in Resident Rooms	21	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	(38,745)	30		9
10	Interest and Other Investment Income	(4,352)	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	(2,321)	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 Page 5A</u>	(13,443)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (69,513)		\$	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)	411,302		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 411,302		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 341,789		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	

Villa Scalabrini Nursing & Rehab

ID# 0044792

Report Period Beginning: 07/01/07

Ending: 06/30/08

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	Offset miscellaneous revenue against expense	\$ (13,443)	21
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	(13,443)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Villa Scalabrini Nursing & Rehab

0044792

Report Period Beginning:

07/01/07

Ending:

06/30/08

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	(10,673)	0	0	0	0	0	0	0	0	0	0	(10,673)	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	(10,673)	0	0	0	0	0	0	0	0	0	0	(10,673)	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	(1,070,441)	0	0	0	0	0	0	0	0	0	(1,070,441)	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	(13,422)	1,012,385	0	0	0	0	0	0	0	0	0	998,963	21
22	Employee Benefits & Payroll Taxes	0	325,827	0	0	0	0	0	0	0	0	0	325,827	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	(13,422)	267,771	0	254,349	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(24,095)	267,771	0	243,676	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Villa Scalabrini Nursing & Rehab # 0044792 Report Period Beginning: 07/01/07 Ending: 06/30/08

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I		
30	Depreciation	(38,745)	121,274	0	0	0	0	0	0	0	0	0	82,529	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(4,352)	22,257	0	0	0	0	0	0	0	0	0	17,905	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	(43,097)	143,531	0	100,434	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):*	(2,321)	0	0	0	0	0	0	0	0	0	0	(2,321)	43
44	TOTAL Special Cost Centers	(2,321)	0	0	0	0	0	0	0	0	0	0	(2,321)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(69,513)	411,302	0	341,789	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
<u>Resurrection Health Care</u>	<u>100</u>	<u>See Attached</u>		<u>See Attached</u>		

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	<u>21 Clerical & data processing</u>	\$	<u>Resurrection Health Care</u>	<u>100.00%</u>	<u>\$ 1,012,385</u>	<u>\$ 1,012,385</u>	<u>1</u>
2	V	<u>22 Employee benefits</u>		<u>Resurrection Health Care</u>	<u>100.00%</u>	<u>325,827</u>	<u>325,827</u>	<u>2</u>
3	V	<u>30 Depreciation</u>		<u>Resurrection Health Care</u>	<u>100.00%</u>	<u>121,274</u>	<u>121,274</u>	<u>3</u>
4	V	<u>32 Interest</u>		<u>Resurrection Health Care</u>	<u>100.00%</u>	<u>22,257</u>	<u>22,257</u>	<u>4</u>
5	V							<u>5</u>
6	V							<u>6</u>
7	V	<u>17 Intercompany expense</u>	<u>1,070,441</u>	<u>Resurrection Health Care</u>	<u>100.00%</u>		<u>(1,070,441)</u>	<u>7</u>
8	V	<u>39 Intercompany pharmacy</u>	<u>1,681,847</u>	<u>Resurrection Health Care</u>	<u>100.00%</u>	<u>1,681,847</u>		<u>8</u>
9	V							<u>9</u>
10	V							<u>10</u>
11	V							<u>11</u>
12	V							<u>12</u>
13	V							<u>13</u>
14	Total		\$ 2,752,288			\$ 3,163,590	\$ * 411,302	14

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

Facility Name & ID Number Villa Scalabrini Nursing & Rehab # 0044792 Report Period Beginning: 07/01/07 Ending: 06/30/08

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference
						Hours	Percent	Description	Amount	
1	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 Villa Scalabrini Nursing & Rehab

0044792

Report Period Beginning:

07/01/07

Ending: 06/30/08

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization 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			\$	\$		\$ 1,012,385	1
2	22	Employee benefits						325,827	2
3	30	Depreciation						121,274	3
4	32	Interest						22,257	4
5									5
6									6
7	39	Intercompany Pharmacy							7
8								1,681,847	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				\$	\$		\$ 3,163,590	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Villa Scalabrini Nursing & Rehab

0044792

Report Period Beginning:

07/01/07

Ending:

06/30/08

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							\$	\$			\$	1						
2												2						
3												3						
4												4						
5												5						
Working Capital																		
6												6						
7												7						
8												8						
9	TOTAL Facility Related						\$	\$			\$	9						
B. Non-Facility Related*																		
10							Allocated from Home Office					22,257	10					
11							Offset Interest Income					(4,352)	11					
12													12					
13													13					
14	TOTAL Non-Facility Related						\$	\$			\$	17,905	14					
15	TOTALS (line 9+line14)						\$	\$			\$	17,905	15					

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

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

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

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

(See instructions.)

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

B. Real Estate Taxes

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

1. Real Estate Tax accrual used on 2007 report.		\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	2
3. Under or (over) accrual (line 2 minus line 1).		\$	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2003	8	
	2004	9	
	2005	10	
	2006	11	
	2007	N/A	12
This 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 Villa Scalabrini Nursing & Rehab COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0044792

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. <u>This facility is a not-for-profit and does not pay real estate tax.</u>		\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
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 Villa Scalabrini Nursing & Rehab

0044792

Report Period Beginning:

07/01/07

Ending:

06/30/08

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 195,174 B. General Construction Type: Exterior Brick Frame Steel/Concrete Number of Stories One

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>696,960</u>	<u>2000</u>	<u>\$ 1,500,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	696,960		\$ 1,500,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Villa Scalabrini Nursing & Rehab

0044792

Report Period Beginning:

07/01/07

Ending:

06/30/08

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	253	2000		\$ 7,510,695	\$ 250,712	35	\$ 214,591	\$ (36,121)	\$ 1,996,230	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Illuminated display sign		2000	9,374	937	20	469	(468)	3,752	9
10	Redecorating		2001	6,181	618	10	618		3,401	10
11	Sign		2001	6,805	681	20	340	(341)	2,720	11
12	Roof repair		2001	4,246	425	20	212	(213)	1,696	12
13	Condensor		2000	2,185	312	20	109	(203)	872	13
14	Monitoring system		2000	1,592	227	20	80	(147)	640	14
15	Refrigeration service		2001	1,650	236	20	83	(153)	662	15
16	Air conditioning repair		2001	576	82	20	29	(53)	203	16
17	Display		2001	1,629	233	20	81	(152)	567	17
18	Kitchen floor		2002	625	89	20	31	(58)	217	18
19	Air conditioning repair		2002	744	106	20	37	(69)	259	19
20	Electrical wiring		2002	1,000	143	20	50	(93)	305	20
21	Roof repair		2001	614	61	20	31	(30)	217	21
22	Illuminated display		2001	4,199	420	20	210	(210)	1,470	22
23	Renovations		2002	2,385	238	20	119	(119)	833	23
24	Canopy		2002	2,100	210	20	105	(105)	645	24
25	Sewer line		2002	4,200	420	20	210	(210)	1,470	25
26										26
27										27
28	Reclass from moveable equipment:									
29	Replace 20-ton Trane compressor		2002	7,791	779	10	779		4,285	29
30	Rewiring of emergency nurse call		2003	6,995	700	10	700		3,850	30
31	Patch foundation wall at handicap ramp		2003	19,850	1,323	15	1,323		7,277	31
32										32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Villa Scalabrini Nursing & Rehab

0044792

Report Period Beginning:

07/01/07

Ending:

06/30/08

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Door openers	2003	\$ 7,876	\$ 788	10	\$ 788	\$	\$ 3,546	37
38	Replacement-Expansion joints	2003	14,347	1,435	10	1,435		6,457	38
39	Fiber optic system upgrade	2003	9,343	1,869	5	1,869		8,408	39
40	South wing renovation	2004	23,112	1,156	20	1,156		5,202	40
41	Replace drain pipes	2004	5,092	339	15	339		1,526	41
42	Corridor carpet	2004	2,128	142	15	142		639	42
43	Pressure guages (4)	2004	8,851	1,770	5	1,770		7,965	43
44	Bumper guards	2004	2,392	239	10	239		1,077	44
45	Network closet - Dietary	2004	5,761	230	25	230		1,035	45
46	Nurses call station	2004	56,946	5,695	10	5,695		25,627	46
47									47
48	Sealcoat, crack fill & repair parking lot	2005	6,784	678	10	678		2,373	48
49	Carpet & installation	2005	2,128	426	5	426		1,491	49
50	Remodel Central Supply room	2005	1,928	241	8	241		843	50
51	Replacement of broken roof & barrel tiles	2005	17,026	1,703	10	1,703		5,960	51
52	Alternating Low Air Loss system	2005	26,120	1,741	15	1,741		6,094	52
53	Category 5E cable run for central supply room	2005	1,190	119	10	119		416	53
54	Ceramic tile & installation in smoking area	2005	3,950	263	15	263		921	54
55	Duct work for air conditioner run in laundry	2005	2,800	280	10	280		980	55
56	Fire protection system addition	2005	1,735	116	15	116		406	56
57	Roller latched for Units A & B	2005	7,828	783	10	783		2,740	57
58	Reflective tempered insulation	2005	2,929	366	8	366		1,281	58
59	Trane Compressors (2)	2005	862	172	5	172		530	59
60	Trane air conditioners (2)	2005	8,620	862	10	862		2,658	60
61	Entry door system	2005	4,260	852	5	852		2,627	61
62	Emergency lighting, phones system for elevators	2005	6,312	789	8	789		2,433	62
63									63
64	Signage installation	2006	2,516	504	5	504		1,260	64
65	Install amp circuits	2006	8,444	563	15	563		1,407	65
66	Replacement Pumps	2006	2,843	284	10	284		710	66
67	Install four voice cables	2006	4,154	593	7	593		1,483	67
68	Connect new storm line	2006	7,500	750	10	750		1,875	68
69	Install guardrails	2006	15,120	1,008	15	1,008		2,520	69
70	TOTAL (lines 4 thru 69)		\$ 7,866,333	\$ 285,708		\$ 246,963	\$ (38,745)	\$ 2,134,061	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Villa Scalabrini Nursing & Rehab

0044792

Report Period Beginning:

07/01/07

Ending:

06/30/08

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 7,866,333	\$ 285,708		\$ 246,963	\$ (38,745)	\$ 2,134,061	1
2	<u>Knee walls improvement</u>	2006	4,900	327	15	327		817	2
3	<u>Oak Door</u>	2006	1,644	110	15	110		275	3
4	<u>Water softner system</u>	2006	7,157	895	8	895		2,237	4
5	<u>Replace baffle tile and refractory</u>	2006	5,513	551	10	551		1,378	5
6	<u>Drain pans</u>	2006	7,510	751	10	751		1,878	6
7	<u>Generator repairs</u>	2006	4,705	471	10	471		1,177	7
8	<u>Boiler repairs</u>	2006	9,950	995	10	995		2,488	8
9	<u>Asbestos removal - Steam Pipe</u>	2006	2,725	182	15	182		455	9
10	<u>Modify High Pressure Piping</u>	2006	7,680	768	10	768		1,920	10
11	<u>S. wing carpentry, drywall, plumbing, electrical, HVAC, floors, ce</u>	2006	1,572,607	68,772	20-25	68,772		171,930	11
12	<u>Survey & Removal of Asbestos</u>	2006	133,728	5,349	25	5,349		13,425	12
13	<u>Geotechnical Investigation</u>	2006	3,071	123	25	123		307	13
14	<u>Borger Responder IV Nurse Call System</u>	2006	48,550	1,942	25	1,942		4,854	14
15	<u>Paint & wallpaper for Units A & G</u>	2006	17,500	1,167	15	1,167		2,859	15
16	<u>Modify Exhaust Fan System</u>	2006	2,085	209	10	209		522	16
17	<u>Tile and floor base for Unit D</u>	2006	1,600	107	15	107		267	17
18	<u>Battery Powered Emergency Lights</u>	2006	6,620	662	10	662		1,655	18
19	<u>Repipe water lines for new controller</u>	2006	1,951	130	15	130		325	19
20	<u>Private office renovation</u>	2006	1,443	206	7	206		515	20
21	<u>Remove door guards from all doors in Units B,C,D</u>	2006	2,700	270	10	270		675	21
22	<u>Spence Valve thermostat</u>	2006	2,650	265	10	265		663	22
23	<u>Carpet & Vinyl base for Unit A corridor</u>	2006	18,550	1,855	10	1,855		4,637	23
24	<u>2 Steam bundles for hot storage tank</u>	2006	10,700	1,070	10	1,070		2,675	24
25	<u>Furnish & Install north & south dock doors in Dietary</u>	2006	5,808	387	15	387		968	25
26	<u>Locate leak in underground piping</u>	2006	1,531	306	5	306		495	26
27	<u>2 - 25mpc100, heavy duty self priming</u>	2006	16,877	1,125	15	1,125		2,813	27
28	<u>Install 2 steam bucket traps in tunnel for heat</u>	2006	1,773	118	15	118		295	28
29	<u>Doors & frames for receiving area</u>	2006	9,356	624	15	624		1,559	29
30	<u>Faucets</u>	2006	6,560	656	10	656		1,640	30
31	<u>Install new modified Bitumen</u>	2006	2,300	230	10	230		368	31
32	<u>Universal 25-27" TV wall mounts</u>	2006	969	97	10	97		242	32
33	<u>Fire Alarm</u>	2006	1,650	83	20	83		207	33
34	TOTAL (lines 1 thru 33)		\$ 9,788,696	\$ 376,511		\$ 337,766	\$ (38,745)	\$ 2,360,582	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Villa Scalabrini Nursing & Rehab

0044792

Report Period Beginning:

07/01/07

Ending:

06/30/08

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 9,788,696	\$ 376,511		\$ 337,766	\$ (38,745)	\$ 2,360,582	1
2	Test, inspect & lubricate 626 fire dampers & install access panel	2006	20,894	2,090	10	2,090		3,135	2
3	Replace garden storage room ceiling	2006	5,400	1,080	5	1,080		1,620	3
4	Replace 4 sets of sliding doors	2006	7,545	754	10	754		1,132	4
5	Tie in 6 gal. Kiddie Hood System to main fire alarm control panel	2006	4,615	462	10	462		692	5
6	Install (2) 20amp circuits for sign, install photo cell trenching	2006	5,791	724	8	724		1,086	6
7	Install double face interior illuminated lighting	2006	24,966	3,566	7	3,566		5,349	7
8	Install motors, thermostats & transmitters	2006	13,578	1,698	8	1,698		2,547	8
9	Remove and replace tiles and baseboards	2006	13,500	1,688	8	1,688		2,532	9
10	Prepare and paint ceiling & walls in all residential rooms	2006	8,950	1,790	5	1,790		2,685	10
11	Tear off existing carpet in all resident rooms	2006	11,700	1,462	8	1,462		2,193	11
12	Baton Draperies for Units A, B, C, D, E & F resident rooms	2006	31,983	3,748	8-10	3,748		5,622	12
13	Furnish & Install 32 Push/Pull Latch sets - 1st & 2nd floors	2006	5,685	710	8	710		1,065	13
14	Remove and replace compressor for G South	2006	8,906	944	8-10	944		1,416	14
15	Start & check all A/C units	2006	10,404	2,080	5	2,080		3,120	15
16	Remove and replace high pressure & relief valves on boiler	2006	13,038	2,608	5	2,608		3,912	16
17	Conservation/Restoration of ICON	2007	4,950	494	10	494		742	17
18	South Wing Renovation -Architecture Fees	2007	51,390	10,278	5	10,278		15,417	18
19	Cleaning & masonry repair - West elevation of the fron entry	2007	36,001	1,802	20	1,802		2,703	19
20	Replacement Draperies for Unit B, C, D & E	2007	3,113	390	8	390		585	20
21	Boiler repairs	2007	20,535	4,106	5	4,106		6,159	21
22	Renovate existing wing - Project Submission - IDPH	2007	10,849	1,550	7	1,550		2,325	22
23									23
24	Glass & Reglazing	2007	5,535	191	15	191		191	24
25	Asphalt tar sealing & restriping	2007	3,670	245	8	245		245	25
26	Emergency doors	2007	10,970	281	20	281		281	26
27	5 electric drips for five offices	2008	7,225	185	20	185		185	27
28	Dining room door hardware	2008	2,955	328	5	328		328	28
29	Life Safety Code consultation	2008	7,464	829	3	829		829	29
30	Remove & replace doors per Life Safety code	2008	30,234	775	20	775		775	30
31									31
32	Home Office Allocation					121,274	121,274		32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,170,542	\$ 423,369		\$ 505,898	\$ 82,529	\$ 2,429,453	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	\$ 657,480	\$ 55,293	\$ 55,293	\$	5-20	\$ 178,764	71
72	Current Year Purchases	228,598	12,684	12,684		3-20	12,684	72
73	Fully Depreciated Assets	1,853,924					1,853,924	73
74								74
75	TOTALS	\$ 2,740,002	\$ 67,977	\$ 67,977	\$		\$ 2,045,372	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										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)	\$ 14,410,544	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 491,346	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 573,875	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 82,529	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,474,825	85

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

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

G. Construction-in-Progress

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

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

** This must agree with Schedule V line 30, column 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				N/A			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: \$ 34,426 Description: Copier - 8067; Specialty mattresses & beds - 26359

(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.	<u>/2009</u>	\$ _____
13.	<u>/2010</u>	\$ _____
14.	<u>/2011</u>	\$ _____

* 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?</p> <p><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. CLASSROOM PORTION:</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. CLINICAL PORTION:</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	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	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(1,2,3)	1955 hrs	\$ 77,533	566	\$ 35,784	\$ 6,208	2,521	\$ 119,525	1
2	Licensed Speech and Language Development Therapist	10A(1,2,3)	68 hrs	2,697	11	681	216	79	3,594	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(1,2,3)	4495 hrs	178,211	786	41,327	14,270	5,281	233,808	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				1,681,847		1,681,847	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			\$ 258,441	1,363	\$ 77,792	\$ 1,702,541	7,881	\$ 2,038,774	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 Villa Scalabrini Nursing & Rehab

0044792

Report Period Beginning: 07/01/07

Ending:

06/30/08

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/08

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,888,817	\$ 1,888,817	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 939,342)	2,211,944	2,211,944	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	6,604	6,604	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,107,365	\$ 4,107,365	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	1,500,000	1,500,000	13
14	Buildings, at Historical Cost	9,773,575	7,510,695	14
15	Leasehold Improvements, at Historical Cost	23,837	2,659,847	15
16	Equipment, at Historical Cost	3,161,071	2,740,002	16
17	Accumulated Depreciation (book methods)	(4,596,659)	(4,474,825)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	78,000	78,000	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(75,400)	(75,400)	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)	\$ 9,864,424	\$ 9,938,319	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 13,971,789	\$ 14,045,684	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 195,375	\$ 195,375	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	<u>Due to Related Entities</u>	2,429,194	2,429,194	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,624,569	\$ 2,624,569	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)	\$ 2,624,569	\$ 2,624,569	46
47	TOTAL EQUITY(page 18, line 24)	\$ 11,347,220	\$ 11,421,115	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 13,971,789	\$ 14,045,684	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 9,837,218	1
2	Restatements (describe):		2
3	Prior Period Adjustment	414,668	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 10,251,886	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,095,334	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 1,095,334	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)	\$ 11,347,220	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	\$ 19,144,739	1
2	Discounts and Allowances for all Levels	(6,642,668)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 12,502,071	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,608,796	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,608,796	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	10,673	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	16,404	16
17	Sale of Drugs	1,980,027	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	638,550	21
22	Laundry	40,833	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 2,686,487	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	4,352	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 4,352	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Schedule 19A</u>	36,907	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 36,907	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 16,838,613	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,568,302	31
32	Health Care	6,456,928	32
33	General Administration	4,377,315	33
	B. Capital Expense		
34	Ownership	525,772	34
	C. Ancillary Expense		
35	Special Cost Centers	1,684,168	35
36	Provider Participation Fee	130,794	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 15,743,279	40
41	Income before Income Taxes (line 30 minus line 40)**	1,095,334	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,095,334	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.

Villa Scalabarini Nursing & Rehab

Provider #: 0044792

07/01/07 - 06/30/08

Schedule 19A

Schedule XVII - Income Statement: Line 88 - Other Revenue

Vending Commission	825
Receipts from Temporary Restricted Fun	<u>36,082</u>
To P19, Sch XVII(A), L28	<u><u>36,907</u></u>

Facility Name & ID Number Villa Scalabrini Nursing & Rehab

0044792

Report Period Beginning:

07/01/07

Ending:

06/30/08

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,856	2,080	\$ 93,658	\$ 45.03	1
2	Assistant Director of Nursing	1,856	2,080	78,879	37.92	2
3	Registered Nurses	62,979	71,092	2,327,517	32.74	3
4	Licensed Practical Nurses	12,022	14,567	349,985	24.03	4
5	CNAs & Orderlies	146,538	163,931	2,107,818	12.86	5
6	CNA Trainees					6
7	Licensed Therapist	5,864	6,518	258,441	39.65	7
8	Rehab/Therapy Aides	9,714	10,979	185,693	16.91	8
9	Activity Director	8	8	220	27.50	9
10	Activity Assistants	11,616	13,033	152,682	11.72	10
11	Social Service Workers	932	1,060	27,085	25.55	11
12	Dietician	2,936	3,393	74,086	21.83	12
13	Food Service Supervisor	1,808	2,080	49,880	23.98	13
14	Head Cook	9,158	10,300	139,021	13.50	14
15	Cook Helpers/Assistants	26,582	29,441	293,745	9.98	15
16	Dishwashers					16
17	Maintenance Workers	7,535	8,689	157,722	18.15	17
18	Housekeepers	21,967	24,777	263,401	10.63	18
19	Laundry	12,988	14,863	161,949	10.90	19
20	Administrator	976	1,080	66,971	62.01	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	22,121	24,646	417,216	16.93	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	5,032	5,522	178,772	32.37	32
33	Other(specify) <u>Religious Salaries</u>	8,652	8,732	188,472	21.58	33
34	TOTAL (lines 1 - 33)	373,140	418,871	\$ 7,573,213 *	\$ 18.08	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	14,000	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 14,000		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses			50	
51	Licensed Practical Nurses			51	
52	Certified Nurse Assistants/Aides	392	7,848	10(3)	52
53	TOTAL (lines 50 - 52)	392	\$ 7,848		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 Villa Scalabrini Nursing & Rehab

0044792

Report Period Beginning:

07/01/07

Ending:

06/30/08

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. Life Services Network of Illinois dues-2625
- (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? 11.5 yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 23,158 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/
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 130,794
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. \$ None Has any meal income been offset against related costs? Yes Indicate the amount. \$ 10,673
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation. N/A
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such 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