

Facility Name & ID Number Saint Clare Home

0044024 Report Period Beginning: 10/01/2008 Ending: 09/30/2009

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	60	Skilled (SNF)	60	21,900	1
2		Skilled Pediatric (SNF/PED)			2
3	34	Intermediate (ICF)	34	12,410	3
4		Intermediate/DD			4
5	4	Sheltered Care (SC)	4	1,460	5
6		ICF/DD 16 or Less			6
7	98	TOTALS	98	35,770	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total	
		3 Medicaid Recipient	4 Private Pay	Other	Total		
8	SNF	11,827	9,502	2,386	23,715	8	
9	SNF/PED					9	
10	ICF					10	
11	ICF/DD					11	
12	SC	337	710		1,047	12	
13	DD 16 OR LESS					13	
14	TOTALS	12,164	10,212	2,386	24,762	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 69.23%

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)

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 09/01/1998

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 60 and days of care provided _____

Medicare Intermediary Wisconsin Physicians Service

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: _____ Fiscal Year: _____

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

Facility Name & ID Number Saint Clare Home # 0044024 Report Period Beginning: 10/01/2008 Ending: 09/30/2009

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	252,971	21,182	167	274,320		274,320		274,320		1
2	Food Purchase		221,021		221,021		221,021		221,021		2
3	Housekeeping	130,169	19,917	284	150,370		150,370		150,370		3
4	Laundry	53,228	9,642	8,711	71,581		71,581		71,581		4
5	Heat and Other Utilities			127,479	127,479		127,479		127,479		5
6	Maintenance	62,322	51,437	46,440	160,199		160,199		160,199		6
7	Other (specify):*										7
8	TOTAL General Services	498,690	323,199	183,081	1,004,970		1,004,970		1,004,970		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	1,399,918	107,626	154,345	1,661,889		1,661,889	(9,692)	1,652,197		10
10a	Therapy	36,656	149,788	210,372	396,816	(149,788)	247,028		247,028		10a
11	Activities	60,973	6,875	3,661	71,509		71,509		71,509		11
12	Social Services	30,820	470		31,290		31,290		31,290		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* LAB & X-RAY			18,530	18,530	(18,530)					15
16	TOTAL Health Care and Programs	1,528,367	264,759	386,908	2,180,034	(168,318)	2,011,716	(9,692)	2,002,024		16
	C. General Administration										
17	Administrative	89,297			89,297		89,297		89,297		17
18	Directors Fees										18
19	Professional Services			49,510	49,510	9,588	59,098	363,314	422,412		19
20	Dues, Fees, Subscriptions & Promotions			94,434	94,434	(52,834)	41,600	(13,467)	28,133		20
21	Clerical & General Office Expenses	202,450	6,526	79,083	288,059	(150)	287,909	(41,640)	246,269		21
22	Employee Benefits & Payroll Taxes			553,150	553,150	150	553,300		553,300		22
23	Inservice Training & Education										23
24	Travel and Seminar			5,910	5,910		5,910		5,910		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			30,976	30,976		30,976		30,976		26
27	Other (specify):* CHAPLAIN	48,455			48,455		48,455		48,455		27
28	TOTAL General Administration	340,202	6,526	813,063	1,159,791	(43,246)	1,116,545	308,207	1,424,752		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,367,259	594,484	1,383,052	4,344,795	(211,564)	4,133,231	298,515	4,431,746		29

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

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

Facility Name & ID Number

Saint Clare Home

#0044024

Report Period Beginning:

10/01/2008

Ending:

09/30/2009

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			294,484	294,484	(8,219)	286,265		286,265			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			51,894	51,894		51,894	(2,890)	49,004			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			5,194	5,194		5,194		5,194			35
36	Other (specify):*											36
37	TOTAL Ownership			351,572	351,572	(8,219)	343,353	(2,890)	340,463			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					168,318	168,318		168,318			39
40	Barber and Beauty Shops		144	18,545	18,689		18,689		18,689			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					51,465	51,465		51,465			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		144	18,545	18,689	219,783	238,472		238,472			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,367,259	594,628	1,753,169	4,715,056		4,715,056	295,625	5,010,681			45

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

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(2,890)	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	(14,885)	21		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	(40,222)	21		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (57,997)		\$	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)	363,314	19	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 363,314		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 305,317		37

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

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

		1	2	3	4
		Yes	No	Amount	Reference
38	Medically Necessary Transport.			\$	38
39					39
40	Gift and Coffee Shops				40
41	Barber and Beauty Shops				41
42	Laboratory and Radiology			18,530	15
43	Prescription Drugs			149,788	10a
44					44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	TOTAL (C): (sum of lines 38-46)			\$ 168,318	47

BHF USE ONLY

48		49		50		51		52
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Saint Clare Home

ID# 0044024

Report Period Beginning: 10/01/2008

Ending: 09/30/2009

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Imputed amount of Nonpaid Worker	\$ (9,692)	10	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	(9,692)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Saint Clare Home# 0044024

Report Period Beginning:

10/01/2008

Ending:

09/30/2009

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

	Operating Expenses	PAGES	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	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	0	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	(9,692)	0	0	0	0	0	0	0	0	0	0	(9,692)	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	(9,692)	0	(9,692)	16									
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	363,314	0	0	0	0	0	0	0	0	0	0	363,314	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(55,107)	0	0	0	0	0	0	0	0	0	0	(55,107)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	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	308,207	0	308,207	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	298,515	0	298,515	29									

STATE OF ILLINOIS

Facility Name & ID Number Saint Clare Home# 0044024

Report Period Beginning:

10/01/2008 Ending:

Summary B

09/30/2009

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,890)	0	0	0	0	0	0	0	0	0	0	(2,890)	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	(2,890)	0	0	0	0	0	0	0	0	0	0	(2,890)	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):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	295,625	0	0	0	0	0	0	0	0	0	0	295,625	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
OSF Healthcare Systems	100%					

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	Home Office Costs	\$ 26,682		100.00%	\$ 389,996	\$ 363,314	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 26,682			\$ 389,996	\$ * 363,314	14

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

Facility Name & ID Number Saint Clare Home # 0044024 Report Period Beginning: 10/01/2008 Ending: 09/30/2009

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											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

Facility Name & ID Number Saint Clare Home

0044024

Report Period Beginning:

10/01/2008

Ending: 9/30/2009

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

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

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

Facility Name & ID Number

Saint Clare Home

0044024

Report Period Beginning:

10/01/2008

Ending:

09/30/2009

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1										1										
2										2										
3										3										
4										4										
5										5										
Working Capital																				
6	OSF Healthcare System	X		Cash Advances	as required	10/01/2008	655,000	3,236,000	4.5000	51,894	6									
7											7									
8											8									
9	TOTAL Facility Related						\$ 655,000	\$ 3,236,000		\$ 51,894	9									
B. Non-Facility Related*																				
10											10									
11											11									
12											12									
13											13									
14	TOTAL Non-Facility Related						\$	\$		\$	14									
15	TOTALS (line 9+line14)						\$ 655,000	\$ 3,236,000		\$ 51,894	15									

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

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

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

Facility Name & ID Number Saint Clare Home

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X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 26,500 B. General Construction Type: Exterior Brick/Wood Frame Wood Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

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>224,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS			\$ <u>224,000</u>	<u>3</u>

Facility Name & ID Number Saint Clare Home

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	98			\$ 2,682,500	\$		\$	\$	\$
5									
6									
7									
8									
Improvement Type**									
9	Smoke Detector		1999	1,932					
10	Call Light System		1999	16,785					
11	Sewage Ejector Pump		1999	3,800					
12	Door Alarm System		1999	1,275					
13	Chapel Renovation		1999	1,760					
14									
15	Wallpaper/Paint - Remodel Hallways		2000	45,058					
16	Heat/Cool Pump -- Rooftop A?C		2000	8,790					
17	Corridor Renovation		2000	19,472					
18	Cubicle Curtains		2000	4,020					
19	Flooring - Hallways		2000	45,048					
20	Rooftop A/C Units		2000	328,932					
21	Window Treatments		2000	7,221					
22	Sign		2000	720					
23	Chapel Renovation		2000	32,210					
24	Smoke Detectors		2000	3,300					
25									
26	Wallpaper/Paint - Remodel Hallways		2001	8,820					
27	Door Alarm		2001	12,678					
28	Auto Door Opener		2001	1,919					
29	Vinyl Floor Coverings - North and West Wing Rooms		2001	73,863					
30	Vinyl Floor Coverings - North and West Wing Rooms - Labor		2001	3,750					
31	Rooftop A/C Units		2001	88,341					
32	Flooring - Hallways		2001	3,418					
33									
34									
35									
36					261,518		261,518		2,507,569

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Saint Clare Home

0044024

Report Period Beginning:

10/01/2008

Ending:

09/30/2009

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	Security Alarm System	2002	\$ 15,826	\$		\$	\$	\$	37
38	Entry Doors	2002	22,435						38
39	Circulating Pump	2002	4,322						39
40	North Corridor Paint	2002	5,643						40
41	Wallpaper	2002	12,945						41
42	Window Treatments	2002	12,508						42
43									43
44	Phone System	2003	13,908						44
45	North Wing Remodel	2003	888						45
46									46
47	Window Treatments	2004	7,600						47
48	North Wing Remodel Floor Coverings	2004	20,882						48
49	North Wing Remodel Painting	2004	21,350						49
50	North Wing Remodel Fire Alarm	2004	44,859						50
51	North Wing Remodel Doors and Hardware	2004	15,545						51
52	Water heaters	2004	60,098						52
53									53
54	Boilers	2005	74,930						54
55	Asbestos Abatement	2005	2,200						55
56	Air conditioner	2005	14,800						56
57	PTAC Units	2005	76,040						57
58	Air Censor	2005	1,394						58
59									59
60	HVAC System	2006	186,467						60
61	Sidewalk	2007	39,339						61
62	Storage Shed	2008	22,665						62
63	Contractor	2008	135,096						63
64	HVAC Revisions- Roof Replace	2008	59,035						64
65	Fire Protection Sprinkler System	2008	215,898						65
66									66
67	Storage Shed	2009	17,555						67
68	Fire Protection Sprinkler System	2009	67,352						68
69									69
70	TOTAL (lines 4 thru 69)		\$ 4,567,192	\$ 261,518		\$ 261,518	\$	\$ 2,507,569	70

**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	\$ 637,302	\$ 22,295	\$ 22,295	\$		\$ 533,753	71
72	Current Year Purchases	73,568	2,452	2,452			2,452	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 710,870	\$ 24,747	\$ 24,747	\$		\$ 536,205	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)	\$	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 286,265	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 286,265	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,043,774	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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

If NO, see instructions. YES NO

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

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

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

9. Option to Buy: YES NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental? _____

YES NO

16. Rental Amount for movable equipment: \$ _____ Description: _____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$ _____	\$ _____	17
18			_____	_____	18
19			_____	_____	19
20			_____	_____	20
21	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. _____ /2010 \$ _____

13. _____ /2011 \$ _____

14. _____ /2012 \$ _____

* 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>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	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.

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$ 89,858	\$		\$ 89,858	1
2	Licensed Speech and Language Development Therapist		hrs			28,971			28,971	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			91,544			91,544	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts				149,788		149,788	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			\$		\$ 210,373	\$ 149,788		\$ 360,161	14

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

Facility Name & ID Number Saint Clare Home# 0044024Report Period Beginning: 10/01/2008Ending: 09/30/2009

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 09/30/2009

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 101,993	\$	1
2	Cash-Patient Deposits	2,680		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>276,776</u>)	602,004		3
4	Supply Inventory (priced at)	29,561		4
5	Short-Term Investments			5
6	Prepaid Insurance	277,771		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,014,009	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	224,000		13
14	Buildings, at Historical Cost	4,567,192		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	710,870		16
17	Accumulated Depreciation (book methods)	(3,043,774)		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)	\$ 2,458,288	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,472,298	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 91,031	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	2,718		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	70,442		30
31	Accrued Taxes Payable (excluding real estate taxes)	5,192		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>Accrued Vacation/Holiday/Sick pay</u>	156,709		36
37	<u>Reimb Due Medicare</u>	33,400		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 359,492	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	2,036,000		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>Advances Due Corp-Term</u>	1,200,000		43
44	<u>Asset Retirement Obligation</u>	53,600		44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 3,289,600	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,649,092	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (176,793)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,472,298	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 773,232	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 773,232	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(950,025)	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)	\$ (950,025)	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)	\$ (176,793)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Saint Clare Home

0044024

Report Period Beginning: 10/01/2008

Ending: 09/30/2009

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	\$ 4,431,705	1
2	Discounts and Allowances for all Levels	(1,620,737)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,810,968	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	918,830	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 918,830	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	1,181	12
13	Barber and Beauty Care	23,890	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	243,824	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	17,851	19
20	Radiology and X-Ray	5,928	20
21	Other Medical Services	2,495	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 295,168	23
D. Non-Operating Revenue			
24	Contributions	1,130	24
25	Interest and Other Investment Income***	2,890	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 4,020	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Management Fees</u>	28,800	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 28,800	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,057,787	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,004,970	31
32	Health Care	2,011,716	32
33	General Administration	1,108,326	33
B. Capital Expense			
34	Ownership	351,572	34
C. Ancillary Expense			
35	Special Cost Centers	187,007	35
36	Provider Participation Fee	51,465	36
D. Other Expenses (specify):			
37	<u>Bad Debts (not on Schedule V)</u>	292,756	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,007,812	40
41	Income before Income Taxes (line 30 minus line 40)**	(950,025)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (950,025)	43

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

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

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

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

Facility Name & ID Number Saint Clare Home

0044024

Report Period Beginning: 10/01/2008

Ending: 09/30/2009

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	1,966	2,166	\$ 62,981	\$ 29.08	1
2	Assistant Director of Nursing	559	583	15,163	26.01	2
3	Registered Nurses	5,874	6,206	152,350	24.55	3
4	Licensed Practical Nurses	22,345	24,234	529,051	21.83	4
5	CNAs & Orderlies	46,459	49,201	616,631	12.53	5
6	CNA Trainees					6
7	Licensed Therapist	1,317	1,317	36,656	27.83	7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	4,503	4,880	60,973	12.49	10
11	Social Service Workers	2,051	2,182	30,820	14.12	11
12	Dietician					12
13	Food Service Supervisor	19,911	21,444	252,971	11.80	13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	3,458	3,540	62,322	17.61	17
18	Housekeepers	11,202	12,036	130,169	10.81	18
19	Laundry	5,321	5,644	53,228	9.43	19
20	Administrator	2,422	2,507	89,297	35.62	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,158	12,007	202,450	16.86	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	1,665	1,992	23,742	11.92	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Chaplain</u>	1,918	2,086	48,455	23.23	33
34	TOTAL (lines 1 - 33)	142,129	152,025	\$ 2,367,259 *	\$ 15.57	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				36
37	Medical Records Consultant		1,380	21	37
38	Nurse Consultant				38
39	Pharmacist Consultant		600	10	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		408	12	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 2,388		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	73	\$ 2,491	10	50
51	Licensed Practical Nurses	850	27,897	10	51
52	Certified Nurse Assistants/Aides	4,756	82,599	10	52
53	TOTAL (lines 50 - 52)	5,680	\$ 112,987		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Kelly McGrath	Administrator		\$ 89,297	Workers' Compensation Insurance	\$	IDPH License Fee	\$	
				Unemployment Compensation Insurance		Advertising: Employee Recruitment	12,595	
				FICA Taxes		Health Care Worker Background Check (Indicate # of checks performed _____)		
				Employee Health Insurance		Promotional Advertising	13,467	
				Employee Meals		Dues and Subscription	15,538	
				Illinois Municipal Retirement Fund (IMRF)*				
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 89,297			Less: Public Relations Expense	()	
B. Administrative - Other						Non-allowable advertising	(13,467)	
Description			Amount			Yellow page advertising	()	
			\$			TOTAL (agree to Sch. V, line 20, col. 8)		
							\$ 28,133	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL (agree to Schedule V, line 22, col.8)			\$	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
OSF Healthcare Systems	Mgmt Fee		\$ 18,463			\$	Out-of-State Travel	\$ 0
KPMG LLP	Audit		5,625					
FR&R Healthcare Consulting Inc	Consulting Fees		25,422				In-State Travel	744
							Seminar Expense	5,166
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 49,510	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	
								\$ 5,910

* Attach copy of IMRF notifications

**See instructions.

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report?
If YES, give association name and amount. Illinois Health Care Association- \$5860
- (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? _____
- (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? _____
- (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? 15 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 22,758 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 51,465
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ _____ Has any meal income been offset against related costs? NO Indicate the amount. \$ _____
- (16) Travel and Transportation
 - a. Are there costs included for out-of-state travel? _____
If YES, attach a complete explanation.
 - b. Do you have a separate contract with the Department to provide medical transportation for residents? N/A If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
 - c. What percent of all travel expense relates to transportation of nurses and patients? 100%
 - d. Have vehicle usage logs been maintained? YES
 - e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
 - f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
 - 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. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: KPMG LLP
- (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.