

Facility Name & ID Number St Francis Nsg & Rehab Center

0044370 Report Period Beginning: 07/01/2008 Ending: 06/30/2009

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	124	Skilled (SNF)	124	45,260	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	124	TOTALS	124	45,260	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
		3 Medicaid Recipient	Private Pay	4 Other	Total	
8	SNF	25,020	3,899	8,048	36,967	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	25,020	3,899	8,048	36,967	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.68%

D. How many bed-hold days during this year were paid by the Department? N/A (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES NO

I. On what date did you start providing long term care at this location?
Date started 03/08/85

J. Was the facility purchased or leased after January 1, 1978?
YES Date 03/08/85 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 124 and days of care provided 36,967

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 06/30/09 Fiscal Year: 06/30/09

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

Facility Name & ID Number St Francis Nsg & Rehab Center # 0044370 Report Period Beginning: 07/01/2008 Ending: 06/30/2009

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	339,061	55,494	12,073	406,628		406,628	(7,748)	398,880		1
2	Food Purchase		233,447		233,447		233,447		233,447		2
3	Housekeeping	169,616	23,631	5,736	198,983		198,983		198,983		3
4	Laundry	739	194,683	241	195,663		195,663	(5,065)	190,598		4
5	Heat and Other Utilities			144,826	144,826		144,826		144,826		5
6	Maintenance	55,614	4,300	120,634	180,548		180,548		180,548		6
7	Other (specify):*										7
8	TOTAL General Services	565,030	511,555	283,510	1,360,095		1,360,095	(12,813)	1,347,282		8
	B. Health Care and Programs										
9	Medical Director			26,328	26,328		26,328		26,328		9
10	Nursing and Medical Records	2,497,231	121,427	86,964	2,705,622		2,705,622		2,705,622		10
10a	Therapy	303,017	821	79,608	383,446		383,446		383,446		10a
11	Activities	127,846	15,571	17,380	160,797		160,797		160,797		11
12	Social Services	53,096	33	3,920	57,049		57,049		57,049		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,981,190	137,852	214,200	3,333,242		3,333,242		3,333,242		16
	C. General Administration										
17	Administrative	102,685		501,155	603,840		603,840	(501,155)	102,685		17
18	Directors Fees										18
19	Professional Services			95	95		95		95		19
20	Dues, Fees, Subscriptions & Promotions			10,203	10,203		10,203		10,203		20
21	Clerical & General Office Expenses	257,245	32,325	24,389	313,959		313,959	565,608	879,567		21
22	Employee Benefits & Payroll Taxes			1,325,080	1,325,080		1,325,080	246,255	1,571,335		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,943	1,943		1,943		1,943		24
25	Other Admin. Staff Transportation			7,633	7,633		7,633		7,633		25
26	Insurance-Prop.Liab.Malpractice			472,557	472,557		472,557		472,557		26
27	Other (specify):*										27
28	TOTAL General Administration	359,930	32,325	2,343,055	2,735,310		2,735,310	310,708	3,046,018		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,906,150	681,732	2,840,765	7,428,647		7,428,647	297,895	7,726,542		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.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			355,453	355,453		355,453	76,507	431,960			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							16,137	16,137			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			39,560	39,560		39,560		39,560			35
36	Other (specify):*											36
37	TOTAL Ownership			395,013	395,013		395,013	92,644	487,657			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		773,094		773,094		773,094		773,094			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			67,890	67,890		67,890		67,890			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		773,094	67,890	840,984		840,984		840,984			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,906,150	1,454,826	3,303,668	8,664,644		8,664,644	390,539	9,055,183			45

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

St Francis Nsg & Rehab Center

ID# 0044370

Report Period Beginning: 07/01/2008

Ending: 06/30/2009

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	Misc Revenue	\$ (2,587)	21
2			
3			
4			
5			
6			
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47			
48			
49	Total	(2,587)	

STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

07/01/2008

Ending:

06/30/2009

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

	Operating Expenses	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)	
	A. General Services													
1	Dietary	(7,748)	0	0	0	0	0	0	0	0	0	0	(7,748)	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	(5,065)	0	0	0	0	0	0	0	0	0	0	(5,065)	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	(12,813)	0	0	0	0	0	0	0	0	0	0	(12,813)	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	(501,155)	0	0	0	0	0	0	0	0	0	(501,155)	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	(7,351)	572,959	0	0	0	0	0	0	0	0	0	565,608	21
22	Employee Benefits & Payroll Taxes	0	246,255	0	0	0	0	0	0	0	0	0	246,255	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	(7,351)	318,059	0	310,708	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(20,164)	318,059	0	297,895	29								

STATE OF ILLINOIS

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

Report Period Beginning:

07/01/2008 Ending:

Summary B

06/30/2009

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	76,507	0	0	0	0	0	0	0	0	0	76,507	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	16,137	0	0	0	0	0	0	0	0	0	16,137	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	0	92,644	0	92,644	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)	(20,164)	410,703	0	0	0	0	0	0	0	0	0	390,539	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:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	<u>21 Clerical & data processing</u>	\$	<u>Resurrection Health Care</u>	<u>100.00%</u>	\$ <u>572,959</u>	\$ <u>572,959</u>	1
2	V	<u>22 Employee benefits</u>		<u>Resurrection Health Care</u>	<u>100.00%</u>	<u>246,255</u>	<u>246,255</u>	2
3	V	<u>30 Depreciation</u>		<u>Resurrection Health Care</u>	<u>100.00%</u>	<u>76,507</u>	<u>76,507</u>	3
4	V	<u>32 Interest</u>		<u>Resurrection Health Care</u>	<u>100.00%</u>	<u>16,137</u>	<u>16,137</u>	4
5	V							5
6	V							6
7	V	<u>17 Intercompany Expense</u>	<u>501,155</u>	<u>Resurrection Health Care</u>	<u>100.00%</u>		<u>(501,155)</u>	7
8	V	<u>39 Intercompany Pharmacy</u>	<u>773,094</u>	<u>Resurrection Health Care</u>	<u>100.00%</u>	<u>773,094</u>		8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,274,249			\$ 1,684,952	\$ * 410,703	14

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

Resurrection Health Care
Schedule for Form 990
Page 5, Part VI, Line 80b
Related Organizations
Twelve Months Ending June 30, 2009

Related Organizations	Fed Tax ID No	Tax Status
Family Medical Network	36-3961066	Non-Exempt
Holy Family Health Care Systems, Inc.	36-3495969	Exempt
Holy Family Nursing & Rehab Center	36-3121158	Exempt
Holy Family Medical Center	36-2439318	Exempt
Key Opportunities Inc.	36-3499869	Non-Exempt
L. Gilbraith Insurance SPC Ltd.		Non-Exempt
Mount Loretto Nursing Home	14-1363014	Exempt
Our Lady of Resurrection Medical Center	36-2644178	Exempt
Proviso Family Services, Inc. - DBA Resurrection Behavioral Health	36-2709982	Exempt
Resurrection Development Foundation	36-3330929	Exempt
Resurrection Health Care	36-2235165	Exempt
Resurrection Health Care Preferred, Inc.	36-3974620	Non-Exempt
Resurrection Home Health Foundation	36-3466794	Exempt
Resurrection Home Health Services	36-2893936	Exempt
Resurrection Medical Center	36-3330926	Exempt
Resurrection Rest Home	14-1348691	Exempt
Resurrection Senior Services	23-7061646	Exempt
Resurrection Services	36-3330928	Exempt
Saint Francis Hospital of Evanston	36-2167800	Exempt
Saint Joseph Hospital	36-3200170	Exempt
Saints Mary and Elizabeth Medical Center	36-2171079	Exempt
Saint Mary of Nazareth PHO	36-4006358	Non-Exempt
Stamana, Inc.	36-3314912	Non-Exempt
Westlake Community Hospital	36-1649520	Exempt
West Suburban Health Providers	36-3980942	Non-Exempt
West Suburban Health Services	36-4286236	Exempt
West Suburban Medical Center	36-2182170	Exempt

RESURRECTION SENIOR SERVICES
BOARD OF DIRECTORS
OCTOBER 1, 2008

Name	Office
Mr. Joseph F. Toomey	President and CEO Resurrection Health Care 7435 W. Talcott Avenue, Suite 520 Chicago, IL 60631 Phone: 773-792-5555; Fax 773-990-8601 Email: DEJesus-ortiz@reshealthcare.org
Sister Donna Marie Wolowicki, C.R.	Executive Vice President/CEO Resurrection Health Care 7435 W. Talcott Avenue, Suite 520 Chicago, IL 60631 Phone: 773-792-5153; Fax - 773-990-7626 Email: srdmarie@reshealthcare.org
Mr. John R. Walton	Group Executive Vice President/CEO Senior Services Holy Family Medical Center 100 North River Road Des Plaines, IL 60016 Phone: 847-813-3160 ; Fax: 847-813-3876 Email: Jwalton@reshealthcare.org
Michael Rosenberg, M.D.	Director, Emergency Medicine Resurrection Medical Center 7435 W. Talcott Avenue, Suite 520 Chicago, IL 60631 Phone: 773-792-5219; Fax 773-594-7980 Email: Morsenberg@reshealthcare.org Director, Emergency Medicine Our Lady of the Resurrection Medical Center 5645 W. Addison Chicago, IL 60634 Phone: 773-794-7602; Fax 773-794-7664 Email: Morsenberg@reshealthcare.org
Sister Elizabeth Trembczynski, CSFN	Administrator Case San Carlo Retirement Community 420 N. Wolf Road Northlake, IL 60164 Phone: 708-561-4300; Fax - 708-562-5677 Email: Etrem@reshealthcare.org

RESURRECTION SENIOR SERVICES
OFFICERS
OCTOBER 1, 2008

Title	Name
President	Mr. Joseph F. Toomey
Group Vice President and EVP/CEO	Mr. John R. Walton
Secretary	Mr. Jeannie C. Frey
Treasurer	Mr. Tom Capobianco
Assistance Secretary	Mr. John R. Walton

Facility Name & ID Number St Francis Nsg & Rehab Center # 0044370 Report Period Beginning: 07/01/2008 Ending: 06/30/2009

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	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

Facility Name & ID Number St Francis Nsg & Rehab Center

0044370

Report Period Beginning:

07/01/2008

Ending: 6/30/2009

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization

Resurrection Health Care/Medical Center

Street Address

7435 West Talcott

City / State / Zip Code

Chicago, IL 60631

Phone Number

(773) 774-8000

Fax Number

(773) 594-7488

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	21	Clerical & data processing			\$	\$		\$ 572,959	1
2	22	Employee benefits						246,255	2
3	30	Depreciation						76,507	3
4	32	Interest						16,137	4
5									5
6									6
7									7
8	39	Intercompany Pharmacy						773,094	8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 1,684,952	25

Facility Name & ID Number

St Francis Nsg & Rehab Center

0044370

Report Period Beginning:

07/01/2008

Ending:

06/30/2009

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		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											6							
7											7							
8											8							
9	TOTAL Facility Related					\$	\$			\$	9							
B. Non-Facility Related*																		
10											10							
11							Allocated from Home Office			16,137	11							
12											12							
13											13							
14	TOTAL Non-Facility Related					\$	\$			\$	16,137	14						
15	TOTALS (line 9+line14)					\$	\$			\$	16,137	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 St Francis Nsg & Rehab Center

0044370

Report Period Beginning:

07/01/2008 Ending:

06/30/2009

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 51,712 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 3

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>51,712</u>	<u>1985</u>	<u>\$ 188,421</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	51,712		\$ 188,421	3

Facility Name & ID Number St Francis Nsg & Rehab Center

0044370

Report Period Beginning:

07/01/2008

Ending:

06/30/2009

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	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	124	1985	1961	\$ 2,426,118	\$ 80,660	30	\$ 80,660	\$	\$ 1,982,493
5									
6									
7									
8									
	Improvement Type**								
9	General Construction/Renovation	1986	1986	12,875		12			12,875
10	General Construction/Renovation	1986	1986	3,543		10			3,543
11	General Construction/Renovation	1986	1986	82,489		15			82,489
12	General Construction/Renovation	1986	1986	44,717		20			44,717
13	General Construction/Renovation	1987	1987	5,529		12			5,529
14	General Construction/Renovation	1987	1987	2,560		10			2,560
15	Inhouse Labor	1988	1988	7,688		5			7,688
16	Shower	1989	1989	3,836	95	20	95		3,836
17	Lobby Refurbish/Exterior Renovation	1991	1991	73,428		5			73,428
18	Dishwasher and Installation	1991	1991	7,332		10			7,332
19	Sidewalk Replacement	1991	1991	4,880		5			4,880
20	Remodel	1993	1993	30,862		15			30,862
21	Vestibule: Wallpaper/Painting; Window Draperies	1996	1996	4,601	307	15	307		3,989
22	Combustion Air Handling System	1996	1996	24,969		10			24,969
23	Fire Alarm System	1996	1996	71,668		10			71,668
24	Parking Lot Repaving	1997	1997	7,162	477	15	477		5,747
25	Roofing: Drain flashing collar; coping replacement								
26	deck repair; masonry repointing; install new drains	1997	1997	74,400	4,960	15	4,960		59,727
27	Admin offices: carpeting; wallpapering & painting;								
28	electrical wiring and lighting	1997	1997	12,270	818	15	818		9,850
29	Renovate 3 Nursing Floors: painting & wallpapering;								
30	install ADA handles & mirrors; carpeting & floor								
31	tiling; installation of glass blocks & window								
32	masonry; installation and modification of light								
33	fixtures; plumbing & H.V.A.C. sprinklers	1997	1997	499,653	33,310	15	33,310		401,109
34	Security Camera System	1997	1997	16,014		10			16,014
35	Parking Lot Repaving	1999	1999	8,530	569	15	569		5,973
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

Facility Name & ID Number St Francis Nsg & Rehab Center

0044370

Report Period Beginning:

07/01/2008 Ending: 06/30/2009

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	Day Room Expansion & Renovation: tear down wall		\$	\$		\$	\$	\$	37
38	between day room & conference room to expand day								38
39	room; install new ceiling & ceiling tiles; new flooring;								39
40	wallpaper & painting; install cupboard & sink; revamp								40
41	closet; window treatment	1999	23,212		10			23,212	41
42	Remove & replace all windows on 1st, 2nd, & 3rd floors	1999	118,907	7,927	15	7,927		83,234	42
43	Acquisition and installation of sternberg lights	2000	7,400	493	15	493		4,685	43
44	Fire dampers/automatic closers	2000	21,493	1,433	15	1,433		13,613	44
45	Vonsuperior Panic Hardware for 9 doors	2000	8,058		7			8,058	45
46	Demolition of existing entrance, waiting area and								46
47	chapel entrance; install flooring, automatic door system,								47
48	anodized store front thermal glazed window system,								48
49	ceiling tile system w/lighting, and wall covering;								49
50	relocate chapel entrance; new concrete sidewalks								50
51	and accessibility ramp.	2000	190,424	19,042	10	19,042		180,901	51
52	Relocate portable fire extinguishers with casing &								52
53	vinyl wallcovering	2001	4,606		5			4,606	53
54	Acquisition/installation exterior concrete bench	2001	2,674		5			2,674	54
55	Acquisition/installation 54"X114" plate glass								55
56	for dayroom	2001	1,350		7			1,350	56
57	Refinish & apply slip grips 36 bathtubs	2001	9,720		5			9,720	57
58	PT/OT renovation: demolition of 2 block walls, casework								58
59	and flooring; install new cabinets; new folding partition;								59
60	new drywall partition; new VCT flooring; paint and vinyl								60
61	wallcovering; plumbing for sinks 7 sprinklers	2001	56,042	5,604	10	5,604		47,635	61
62	Parking lot expansion	2002	536,437	34,878	15	34,878		261,604	62
63	Elevator alarm system	2002	30,000	2,142	7	2,142		30,000	63
64	Building security system	2002	21,710	1,552	7	1,552		21,710	64
65	Solar shades/awning & installation	2002	5,084	481	7	481		5,084	65
66	Window air conditioners & installation	2002	10,439		5			10,439	66
67	IDPH safety code compliance - includes but not limited to:								67
68	protection of lay-in fixtures and equipment;								68
69	automatic door closures tied into fire alarm system which (continued on P12B)								69
70	TOTAL (lines 4 thru 69)		\$ 4,472,680	\$ 194,748		\$ 194,748	\$	\$ 3,569,803	70

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

Facility Name & ID Number St Francis Nsg & Rehab Center

0044370

Report Period Beginning:

07/01/2008 Ending: 06/30/2009

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	
1	Totals from Page 12A, Carried Forward		\$ 4,472,680	\$ 194,748		\$ 194,748	\$	\$ 3,569,803	1
2	is activated by smoke detectors, pull stations and sprinkler								2
3	system; installation of smoke operated fire dampers and								3
4	access panels in exhaust duct system penetrating smoke								4
5	barrier walls located on floors 1, 2 and 3.	2002	481,852	46,597	10	46,597		349,477	5
6	Interior renovation - includes but not limited to:								6
7	Toli floor and ramp; carpet administration area; switch-								7
8	bank for lobby and entrance area; new light fixtures in								8
9	various area; replace piping to boilers; new condensing								9
10	unit to north window well; reheat coil in lobby; replace								10
11	bathroom fixtures; replace/upgrade ceiling in various areas;								11
12	various wall modifications; replace various bathroom								12
13	fixtures; various other electrical and plumbing								13
14	modifications.	2002	159,709	16,549	10	16,549		124,119	14
15	Exterior renovation - includes not limited to: sliding doors;								15
16	removal and replacement of concrete curbs; paving,								16
17	grading and stonework; install new fire ceiling and framing								17
18	in smoking area; new handicap signs; various electrical								18
19	work in outside waiting area (includes new heaters,								19
20	intercom and doorbell).	2002	98,000	6,533	15	6,533		48,998	20
21	Lobby renovation - includes but not limited to: selective								21
22	demolition of existing lobby, toilet room, and reception								22
23	and replacement of each as well as new assisted bathing.								23
24	this includes new partitions, electric plumbing, HVAC,								24
25	acoustic panel ceiling, floor finishes, doors, frames,								25
26	interior windows and casement. Floral fixtures and								26
27	artwork.	2002	166,549	11,732	14	11,732		87,991	27
28	Acquisition/installation of medical records voice and data								28
29	cables, 24-port patch panel, and fire stop & sleeves	2003	4,646	310	15	310		2,015	29
30	2 sewage pumps	2003	5,752	383	15	383		2,490	30
31	Down light style fixtures-acquisition and electrical work	2003	3,780	252	15	252		1,638	31
32	Elevator control valve piping	2003	10,037	1,004	10	1,004		6,526	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,403,005	\$ 278,108		\$ 278,108	\$	\$ 4,193,057	34

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 5,403,005	\$ 278,108		\$ 278,108		\$ 4,193,057	1
2	Remove existing and install new nurse station (1st floor)	2004	8,300	553	15	553		3,002	2
3	Purchase & install quarry tile in kitchen entrance	2004	1,114	111	5	111		1,114	3
4	Grout kitchen floor	2004	4,740	474	10	474		2,607	4
5	Purchase & install raised round rubber tiles in elevator	2004	1,538	152	5	152		1,538	5
6	Purchase & install 2 ceiling 40-gallon ASME coded								6
7	expansion tanks	2004	3,685	368	5	368		3,685	7
8	Purchase & install hot water heater	2004	3,250	216	15	216		1,188	8
9	Purchase & install category 5E wire cable in elevator	2004	758	76	10	76		418	9
10	Replace wood floor with concrete in oxygen storage closet	2004	1,750	116	15	116		638	10
11									11
12	Carpet for lobby and chapel	2005	4,730	955	5	955		2,305	12
13	Overhead domestic water line	2005	1,075	108	10	108		261	13
14	Replace main drain & rod sewer	2005	3,052	203	15	203		491	14
15	Elevator upgrade	2005	6,184	618	10	618		1,491	15
16	Lever drains in three compartment sinks	2005	1,744	174	10	174		418	16
17	Baxtor Flo Guard Pump	2005	5,973	597	10	597		1,594	17
18									18
19	Phase 2 Fireman's Recall	2006	59,921	3,995	15	3,995		13,807	19
20	Upgrade electrical feed for reznor roof top unit	2006	12,950	1,295	10	1,295		4,533	20
21	Replace sprinkler heads in kitchen	2006	2,137	214	10	214		749	21
22	Replace ceiling tiles in kitchen	2006	2,300	153	15	153		536	22
23	Mixer bench gear drive 20qt.	2006	3,820	255	15	255		892	23
24	Vulcan Range 60" burner 20" griddle gas type	2006	3,945	395	10	395		1,382	24
25	Replace window & glaze	2006	4,765	318	15	318		1,113	25
26	Combination Lennox make up air unit	2006	15,000	1,500	10	1,500		5,250	26
27	50 pair cable to north & south wings	2006	4,617	308	15	308		1,078	27
28	Relays, transformers & t-stats on boiler	2006	2,500	250	10	250		875	28
29	Elevator upgrade	2006	14,625	1,462	10	1,462		5,117	29
30									30
31	Replace Concrete	2006	7,100	473	15	473		1,183	31
32	Furnish & Install Fire Rated Wood Doors	2006	2,741	182	15	182		455	32
33	Furnish & Install New Door in Receiving Area	2006	4,230	202	15	202		545	33
34	TOTAL (lines 1 thru 33)		\$ 5,591,549	\$ 293,831		\$ 293,831		\$ 4,251,322	34

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 5,591,549	\$ 293,831		\$ 293,831	\$	\$ 4,251,322	1
2	Inspect & Install 3 Fire Dampers & 3 Access Panels	2006	5,049	505	10	505		1,262	2
3	Remove & Replace tile around sink & paint ceiling in rooms 303 &	2007	3,958	440	9	440		1,100	3
4	Install 6" RPZ valve on fire sprinkler system	2006	7,000	700	10	700		1,750	4
5	Replace Sprinkler Heads on Floors 1, 2 & 3	2007	3,439	491	7	491		1,228	5
6	Replace voice cable on 3rd Floor	2007	14,994	2,142	7	2,142		5,355	6
7	35 American Standard - Madera	2007	6,475	926	7	926		2,315	7
8	Electrical work	2007	6,885	861	8	861		2,152	8
9	Ceiling Tile Toilet Repair Kits	2007	12,400	1,550		1,550		3,875	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	Allocated from Home Office					76,507	76,507		30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,651,749	\$ 301,446		\$ 377,953	\$ 76,507	\$ 4,270,359	34

**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	\$ 988,072	\$ 45,336	\$ 45,336		5-15	\$ 689,943	71
72	Current Year Purchases	113,266	8,671	8,671		5-10	8,671	72
73	Fully Depreciated Assets	816,547					816,547	73
74								74
75	TOTALS	\$ 1,917,885	\$ 54,007	\$ 54,007			\$ 1,515,161	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	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 7,758,055	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 355,453	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 431,960	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 76,507	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 5,785,520	85

**

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

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

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			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: N/A

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

If NO, see instructions. YES NO

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

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

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

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

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 39,560 Description: Copier/Printers - 10806; Therapeutic Equip -Special Beds - 28754

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /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	10A(1,2,3)	2056	hrs	\$ 86,038	736	\$ 45,307	\$	2,792	\$ 131,345	1
2	Licensed Speech and Language Development Therapist	10A(1,2,3)	64	hrs	2,732	140	9,189		204	11,921	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10A(1,2,3)	5344	hrs	203,779	410	22,530		5,754	226,309	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				773,094		773,094	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				\$ 292,549	1,286	\$ 77,026	\$ 773,094	8,750	\$ 1,142,669	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 St Francis Nsg & Rehab Center# 0044370Report Period Beginning: 07/01/2008Ending: 06/30/2009

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/2009

(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	\$ 122,255	\$ 122,255	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>447,686</u>)	906,566	906,566	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	5,846	5,846	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,034,667	\$ 1,034,667	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		188,421	13
14	Buildings, at Historical Cost	4,630,020	2,426,118	14
15	Leasehold Improvements, at Historical Cost	449,987	3,225,631	15
16	Equipment, at Historical Cost	2,489,627	1,917,885	16
17	Accumulated Depreciation (book methods)	(5,771,628)	(5,785,520)	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)	\$ 1,798,006	\$ 1,972,535	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,832,673	\$ 3,007,202	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 119,088	\$ 119,088	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 From Related Entities</u>	10,209,616	10,209,616	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 10,328,704	\$ 10,328,704	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 10,328,704	\$ 10,328,704	46
47	TOTAL EQUITY(page 18, line 24)	\$ (7,496,031)	\$ (7,321,502)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,832,673	\$ 3,007,202	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (6,401,730)	1
2	Restatements (describe):		2
3	Prior Period Adjustment	122,598	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (6,279,132)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,216,899)	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)	\$ (1,216,899)	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)	\$ (7,496,031)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number St Francis Nsg & Rehab Center

0044370

Report Period Beginning: 07/01/2008

Ending: 06/30/2009

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	\$ 8,539,734	1
2	Discounts and Allowances for all Levels	(3,605,020)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,934,714	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,115,736	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,115,736	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	7,747	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,028,273	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	9,802	19
20	Radiology and X-Ray		20
21	Other Medical Services	343,821	21
22	Laundry	5,065	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,394,708	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>misc income</u>	2,587	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,587	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,447,745	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,360,095	31
32	Health Care	3,333,242	32
33	General Administration	2,735,310	33
B. Capital Expense			
34	Ownership	395,013	34
C. Ancillary Expense			
35	Special Cost Centers	773,094	35
36	Provider Participation Fee	67,890	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,664,644	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,216,899)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,216,899)	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.

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

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

0044370

Report Period Beginning: **07/01/2008**

Ending:

06/30/2009

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	1,760	1,899	\$ 82,839	\$ 43.62	1
2	Assistant Director of Nursing					2
3	Registered Nurses	28,303	32,420	1,229,662	37.93	3
4	Licensed Practical Nurses	6,691	7,537	207,726	27.56	4
5	CNAs & Orderlies	57,617	65,198	851,646	13.06	5
6	CNA Trainees					6
7	Licensed Therapist	6,666	7,464	292,550	39.19	7
8	Rehab/Therapy Aides	5,057	5,935	89,332	15.05	8
9	Activity Director					9
10	Activity Assistants	5,428	6,035	80,244	13.30	10
11	Social Service Workers	1,816	1,976	50,184	25.40	11
12	Dietician					12
13	Food Service Supervisor	3,836	4,637	98,564	21.26	13
14	Head Cook	7,236	8,080	114,125	14.12	14
15	Cook Helpers/Assistants	10,959	12,326	133,764	10.85	15
16	Dishwashers					16
17	Maintenance Workers	2,051	2,305	56,016	24.30	17
18	Housekeepers	13,322	14,868	170,208	11.45	18
19	Laundry	52	52	761	14.63	19
20	Administrator	1,896	2,080	105,781	50.86	20
21	Assistant Administrator					21
22	Other Administrative	9,186	10,283	184,386	17.93	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: Care Plan Coord	2,946	3,252	106,753	32.83	32
33	Other(specify) <u>Religious Wages</u>	1,369	1,524	51,609	33.86	33
34	TOTAL (lines 1 - 33)	166,191	187,871	\$ 3,906,150 *	\$ 20.79	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	\$		35	
36	Medical Director	Monthly	26,328	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	\$	26,328		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	178	\$ 10,230	10(3)	50
51	Licensed Practical Nurses	726	30,521	10(3)	51
52	Certified Nurse Assistants/Aides	517	13,109	10(3)	52
53	TOTAL (lines 50 - 52)	1,421	\$ 53,860		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	
Michael Kaplan	Administrator	0	\$ 102,685	Workers' Compensation Insurance	\$ 55,684	IDPH License Fee	\$	
				Unemployment Compensation Insurance	5,881	Advertising: Employee Recruitment		
				FICA Taxes	280,354	Health Care Worker Background Check		
				Employee Health Insurance	699,677	(Indicate # of checks performed _____)		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Life Services Network & AAHSA dues	198	
				Life Insurance	6,672			
				Disability	19,392	Miscellaneous Dues & Subscriptions	3,408	
				Retirement	223,206			
				Employee Morale/Recognition	34,214	Illinois Council on Long-term Care dues	6,597	
				Home Office Allocation	246,255	Less: Public Relations Expense	()	
						Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 102,685	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
				\$ 1,571,335		\$ 10,203		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Management Fees (eliminated in column 7)			\$ 501,155				Out-of-State Travel	\$
							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 501,155				Seminar Expense	
								1,943
							Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 95	TOTAL		\$	TOTAL	\$ 1,943

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number St Francis Nsg & Rehab Center

0044370

Report Period Beginning: 07/01/2008 Ending: 06/30/2009

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. LSNI/AAHSA - 198; ICLTC - 6597; misc 3408
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 7.5 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 10,932 Line 10(2)
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES x NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 67,890
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. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 7,747
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 0
d. Have vehicle usage logs been maintained? Adequate records are 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
- (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.