

Facility Name & ID Number Villa Scalabrini Nursing & Rehab

0044792 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 N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	164	Skilled (SNF)	164	59,860	1
2		Skilled Pediatric (SNF/PED)			2
3	82	Intermediate (ICF)	82	29,930	3
4		Intermediate/DD			4
5	7	Sheltered Care (SC)	7	2,555	5
6		ICF/DD 16 or Less			6
7	253	TOTALS	253	92,345	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	19,887	17,964	17,738	55,589	8
9	SNF/PED					9
10	ICF	24,618	3,127	433	28,178	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	44,505	21,091	18,171	83,767	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.71%

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

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

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census?

Yes

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

YES NO

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

YES NO

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

Date started 03/01/2000

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

YES Date 03/01/2000 NO

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

YES NO If YES, enter number of beds certified 164 and days of care provided 55,589

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: 06/30/2009 Fiscal Year: 06/30/2009

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

Facility Name & ID Number Villa Scalabrini Nursing & Rehab # 0044792 Report Period Beginning: 07/01/2008 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	617,746	69,595	10,319	697,660		697,660	(11,475)	686,185		1
2	Food Purchase		457,629		457,629		457,629		457,629		2
3	Housekeeping	276,908	69,779		346,687		346,687		346,687		3
4	Laundry	186,086	55,254	6,797	248,137		248,137		248,137		4
5	Heat and Other Utilities			425,267	425,267		425,267		425,267		5
6	Maintenance	166,642	953	487,248	654,843		654,843		654,843		6
7	Other (specify):*										7
8	TOTAL General Services	1,247,382	653,210	929,631	2,830,223		2,830,223	(11,475)	2,818,748		8
	B. Health Care and Programs										
9	Medical Director			14,400	14,400		14,400		14,400		9
10	Nursing and Medical Records	5,343,068	384,978	100,411	5,828,457		5,828,457		5,828,457		10
10a	Therapy	519,998	22,403	74,279	616,680		616,680		616,680		10a
11	Activities	169,149	20,439	1,250	190,838		190,838		190,838		11
12	Social Services	261,939	13,595	1,589	277,123		277,123		277,123		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	6,294,154	441,415	191,929	6,927,498		6,927,498		6,927,498		16
	C. General Administration										
17	Administrative			1,122,235	1,122,235		1,122,235	359	1,122,594		17
18	Directors Fees										18
19	Professional Services										19
20	Dues, Fees, Subscriptions & Promotions			18,803	18,803		18,803		18,803		20
21	Clerical & General Office Expenses	374,905	27,077	33,851	435,833		435,833	16,119	451,952		21
22	Employee Benefits & Payroll Taxes			2,859,698	2,859,698		2,859,698	520,334	3,380,032		22
23	Inservice Training & Education										23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation			1,943	1,943		1,943		1,943		25
26	Insurance-Prop.Liab.Malpractice			438,235	438,235		438,235		438,235		26
27	Other (specify):*										27
28	TOTAL General Administration	374,905	27,077	4,474,765	4,876,747		4,876,747	536,812	5,413,559		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	7,916,441	1,121,702	5,596,325	14,634,468		14,634,468	525,337	15,159,805		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

Villa Scalabrini Nursing & Rehab

#0044792

Report Period Beginning:

07/01/2008

Ending:

06/30/2009

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			529,788	529,788		529,788	111,156	640,944			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							27,675	27,675			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			529,788	529,788		529,788	138,831	668,619			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,661,764		1,661,764		1,661,764		1,661,764			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			134,685	134,685		134,685		134,685			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		1,661,764	134,685	1,796,449		1,796,449		1,796,449			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	7,916,441	2,783,466	6,260,798	16,960,705		16,960,705	664,168	17,624,873			45

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

Villa Scalabrini Nursing & Rehab

ID# 0044792

Report Period Beginning: 07/01/2008

Ending: 06/30/2009

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Charity Care Revenue-Recorded as negative	\$		1
2	expense on the trial balance- reversed thru this adj	27,600	21	2
3	Admin- Other Revenue	(16,826)	21	3
4				4
5	Financial Audit Adj - Emp Benefits, workers comp.	17,686	22	5
6	Financial Audit Adj - Emp. Benefits, retirement plan	12,944	22	6
7	Financial Audit Adj - Adm. Other Supplies	5,345	21	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	46,749		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Villa Scalabrini Nursing & Rehab

0044792

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	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	(11,475)	0	0	0	0	0	0	0	0	0	0	(11,475)	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	(11,475)	0	0	0	0	0	0	0	0	0	0	(11,475)	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	359	0	0	0	0	0	0	0	0	0	359	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	16,119	0	0	0	0	0	0	0	0	0	0	16,119	21
22	Employee Benefits & Payroll Taxes	30,630	489,704	0	0	0	0	0	0	0	0	0	520,334	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	46,749	490,063	0	536,812	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	35,274	490,063	0	525,337	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Villa Scalabrini Nursing & Rehab # 0044792 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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I		
30	Depreciation	(38,744)	149,900	0	0	0	0	0	0	0	0	0	111,156	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,943)	31,618	0	0	0	0	0	0	0	0	0	27,675	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	(42,687)	181,518	0	138,831	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
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(7,413)	671,581	0	664,168	45								

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Resurrection Health Care	100	See Attached Page 6A		See Attached Page 6A		

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	17 Administrative	\$ 1,122,235	Resurrection Health Care	100.00%	\$ 1,122,594	\$ 359	1	
2	V	22 Employee Benefits		Resurrection Health Care	100.00%	489,704	489,704	2	
3	V	30 Depreciation		Resurrection Health Care	100.00%	149,900	149,900	3	
4	V	32 Interest		Resurrection Health Care	100.00%	31,618	31,618	4	
5	V							5	
6	V	39 Intercompany Pharmacy	1,661,764	Resurrection Health Care	100.00%	1,661,764		6	
7	V							7	
8	V							8	
9	V							9	
10	V							10	
11	V							11	
12	V							12	
13	V							13	
14	Total		\$ 2,783,999			\$ 3,455,580	\$ *	671,581	14

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

VILLA SCALABRINI NURSING AND REHAB CENTER

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

Facility Name & ID Number Villa Scalabrini Nursing & Rehab # 0044792 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 Pages 7A and 7B								\$	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

**RESURRECTION SENIOR CARE
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

Attachment to Schedule VII - Related Parties
VILLA SCALABRINI NURSING AND REHAB CENTER
Board of Directors

RESURRECTION SENIOR CARE
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 Villa Scalabrini Nursing & Rehab

0044792

Report Period Beginning:

07/01/2008

Ending: 6/30/2009

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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	17	Administrative			\$	\$		1,122,594	1
2	22	Employee Benefits						489,704	2
3	30	Depreciation						149,900	3
4	32	Interest						31,618	4
5									5
6	39	Intercompany Pharmacy						1,661,764	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				\$	\$		3,455,580	25

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

B. Real Estate Taxes

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

1. Real Estate Tax accrual used on 2008 report.		\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	2
3. Under or (over) accrual (line 2 minus line 1).		\$	3
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2004	8
	2005	9
	2006	10
	2007	11
	2008	N/A

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2008	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2008 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2008 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2008.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2008 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2009 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2008 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Villa Scalabrini Nursing & Rehab COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0044792

CONTACT PERSON REGARDING THIS REPORT Thomas W. Groenwald, Controller

TELEPHONE (847) 813-3722 FAX #: (847) 813-3785

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2008 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2008.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>N/A</u>	<u></u>	\$ <u></u>	\$ <u></u>
2. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
3. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
4. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
5. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
6. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
TOTALS		\$ <u></u>	\$ <u></u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES N/A NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2008 tax bills which were listed in Section A to this statement. Be sure to use the 2008 tax bill which is normally paid during 2009.

PLEASE NOTE: *Payment information from the Internet* or otherwise is **not considered acceptable tax bill documentation**. Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number Villa Scalabrini Nursing & Rehab

0044792

Report Period Beginning:

07/01/2008 Ending:

06/30/2009

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

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

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

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>Resident Care</u>	<u>696,960</u>	<u>2000</u>	<u>\$ 1,500,000</u>	1
2					2
3	TOTALS	696,960		\$ 1,500,000	3

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	253	2000		\$ 7,510,695	\$ 250,712	35	\$ 214,591	\$ (36,121)	\$ 2,210,821	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	ILLUMINATED DISPLAY SIGN	2000		9,374	937	20	469	(468)	4,221	9
10	REDECORATING	2001		6,181	618	10	618	0	4,019	10
11	SIGN	2001		6,805	681	20	340	(341)	3,060	11
12	ROOF REPAIR	2001		4,246	425	20	212	(213)	1,908	12
13	CONDENSOR	2000		2,185	312	20	109	(203)	981	13
14	MONITORING SYSTEM	2000		1,592	227	20	80	(147)	720	14
15	REFRIGERATION SERVICE	2001		1,650	236	20	83	(154)	745	15
16	AIR CONDITIONING REPAIR	2001		576	82	20	29	(53)	232	16
17	DISPLAY	2001		1,629	233	20	81	(152)	648	17
18	KITCHEN FLOOR	2002		625	89	20	31	(58)	248	18
19	AIR CONDITIONING REPAIR	2002		744	106	20	37	(69)	296	19
20	ELECTRICAL WIRING	2002		1,000	143	20	50	(93)	355	20
21	ROOF REPAIR	2001		614	61	20	31	(30)	248	21
22	ILLUMINATED DISPLAY SIGN	2001		4,199	420	20	210	(210)	1,680	22
23	RENOVATIONS	2002		2,385	238	20	119	(119)	952	23
24	CANOPY	2002		2,100	210	20	105	(105)	750	24
25	SEWER LINE	2002		4,200	420	20	210	(210)	1,680	25
26										26
27	RECLASS FROM MOVABLE EQUIP	2002		7,791	779	10	779		5,064	27
28	REPLACE 20 TON TRANE COMPRESSOR	2003		6,995	700	10	700		4,550	28
29	REWIRING OF EMERGENCY NURSE CALL	2003		19,850	1,323	15	1,323		8,600	29
30	PATCH FOUNDATION WALL AT HANDICAP RAMP									30
31										31
32										32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Villa Scalabrini Nursing & Rehab

0044792

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	DOOR OPENERS	2003	\$ 7,876	\$ 788	10	\$ 788	\$	\$ 4,334	37
38	REPLACEMENT - EXPANSION JOINTS	2003	14,347	1,435	10	1,435		7,892	38
39	FIBER OPTIC SYSTEM UPGRADE	2003	9,343	1,869	5	1,869		10,277	39
40	SOUTH WING RENOVATION	2004	23,112	1,156	20	1,156		6,358	40
41	REPLACE DRAIN PIPES	2004	5,092	339	15	339		1,865	41
42	CORRIDOR CARPET	2004	2,128	142	15	142		781	42
43	PRESSURE GAUGES	2004	8,851	1,770	5	1,770		9,735	43
44	BUMPER GUARDS	2004	2,392	239	10	239		1,316	44
45	NETWORK CLOSET - DIETARY	2004	5,761	230	25	230		1,265	45
46	NURSE CALL STATION	2004	56,946	5,695	10	5,695		31,322	46
47									47
48	SEALCOAT, CRACK FILL AND REPAIR PARKING LOT	2005	6,784	678	10	678		3,051	48
49	CARPET	2005	2,128	426	5	426		1,917	49
50	REMODEL CENTRAL SUPPLY ROOM	2005	1,928	241	8	241		1,084	50
51	REPLACEMENT OF BROKEN ROOF AND BARREL TILES	2005	17,026	1,703	10	1,703		7,663	51
52	ALTERNATING LOW AIR LOSS SYSTEM	2005	26,120	1,741	15	1,741		7,835	52
53	CATEGORY SE CABLE RUN FOR CENTRAL SUPPLY ROOM	2005	1,190	119	10	119		535	53
54	CERAMIC TILE AND INSTALLATION	2005	3,950	263	15	263		1,184	54
55	DUCT WORK FOR A/C	2005	2,800	280	10	280		1,260	55
56	FIRE PROTECTION SYSTEM ADDITION	2005	1,735	116	15	116		522	56
57	ROLLER LATCHED FOR UNITS	2005	7,828	783	10	783		3,523	57
58	REFLECTIVE TEMPERRED INSULATION	2005	2,929	366	8	366		1,647	58
59	TRANE COMPRESSORS	2005	862	172	5	172		702	59
60	TRAN AIR CONDITIONERS	2005	8,620	862	10	862		3,520	60
61	ENTRY DOOR SYSTEM	2005	4,260	852	5	852		3,479	61
62	EMERGENCY LIGHTING, PHONE SYSTEM FOR ELEVATOR	2005	6,312	789	8	789		3,222	62
63									63
64	SIGNAGE INSTALLATION	2006	2,516	503	5	503		1,763	64
65	INSTALL AMP CIRCUITS	2006	8,444	563	15	563		1,970	65
66	REPLACEMENT PUMPS	2006	2,843	284	10	284		994	66
67	INSTALL FOUR VOICE CABLES	2006	4,154	593	7	593		2,076	67
68	CONNECT NEW STORM LINE	2006	7,500	750	10	750		2,625	68
69	INSTALL GUARD RAILS	2006	15,120	1,008	15	1,008		3,528	69
70	TOTAL (lines 4 thru 69)		\$ 7,866,333	\$ 285,707		\$ 246,963	\$ (38,744)	\$ 2,381,024	70

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

Facility Name & ID Number Villa Scalabrini Nursing & Rehab

0044792

Report Period Beginning:

07/01/2008 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		\$ 7,866,333	\$ 285,707		\$ 246,963	\$ (38,744)	\$ 2,381,024	1
2	<u>KNEE WALLS IMPROVEMENT</u>	2006	4,900	327	15	327		1,144	2
3	<u>OAK DOOR</u>	2006	1,644	110	15	110		385	3
4	<u>WATER SOFTNER SYSTEM</u>	2006	7,157	895	8	895		3,132	4
5	<u>REPLACE BAFFLE TILE AND REFRACTORY</u>	2006	5,513	551	10	551		1,929	5
6	<u>DRAIN PANS</u>	2006	7,510	751	10	751		2,629	6
7	<u>GENERATOR REPAIRS</u>	2006	4,705	471	10	471		1,648	7
8	<u>BOILER REPAIRS</u>	2006	9,950	995	10	995		3,483	8
9	<u>ASBESTOS REMOVAL</u>	2006	2,725	182	15	182		637	9
10	<u>MODIFY HIGH PRESSRE PIPES</u>	2006	7,680	768	10	768		2,688	10
11	<u>S WING CARPENTRY ETC</u>	2006	1,572,607	68,772	20--25	68,772		240,702	11
12	<u>SURVEY AND REMOVAL OF ASBESTOS</u>	2006	133,728	5,349	25	5,349		18,774	12
13	<u>GEOTECHNICAL INVESTIGATION</u>	2006	3,071	123	25	123		430	13
14	<u>BORGER RESPONDER IV NURSE CALL SYSTEM</u>	2006	48,550	1,942	25	1,942		6,796	14
15	<u>PAINT AND WALLPAPER FOR UNITS</u>	2006	17,500	1,167	15	1,167		4,026	15
16	<u>MODIFY EXHAUST FAN SYSTEM</u>	2006	2,085	209	10	209		731	16
17	<u>TILE AND FLOOR BASE FOR UNIT D</u>	2006	1,600	107	15	107		374	17
18	<u>BATTERY POWERED EMERGENCY LIGHTS</u>	2006	6,620	662	10	662		2,317	18
19	<u>REPIPE WAER LINES</u>	2006	1,951	130	15	130		455	19
20	<u>PVT OFC RENOVATIONS</u>	2006	1,443	206	7	206		721	20
21	<u>REOMOVE DOOR GUARDS FROM ALL DOORS</u>	2006	2,700	270	10	270		945	21
22	<u>SPENCE VALVE THERMOSTATS</u>	2006	2,650	265	10	265		928	22
23	<u>CARPET AND VINLY BASE FOR UNIT</u>	2006	18,550	1,855	10	1,855		6,492	23
24	<u>S STEAM BUNDLES</u>	2006	10,700	1,070	10	1,070		3,745	24
25	<u>FURNISH AND INSTALL NORTH AND SOUTH DOCK DOOR</u>	2006	5,808	387	15	387		1,355	25
26	<u>LOCATE LEAK IN UNDERGROUND PIPING</u>	2006	1,531	306	5	306		801	26
27	<u>2-25 MPC 100 HEALVY DUTY SELF PRIMING</u>	2006	16,877	1,125	15	1,125		3,938	27
28	<u>INSTALL 2 STEAM BUCKET TRAPS IN TUNNEL FOR HEAT</u>	2006	1,773	118	15	118		413	28
29	<u>DOORS AND FRAMES FOR RECEIVING AREA</u>	2006	9,356	624	15	624		2,183	29
30	<u>FAUCETS</u>	2006	6,560	656	10	656		2,296	30
31	<u>INSTALL NEW MODIFIED BITUMEN</u>	2006	2,300	230	10	230		598	31
32	<u>UNIVERSAL TV WALL MOUNTS</u>	2006	969	97	10	97		339	32
33	<u>FIRE ALARMS</u>	2006	1,650	83	20	83		290	33
34	TOTAL (lines 1 thru 33)		\$ 9,788,696	\$ 376,508		\$ 337,763	\$ (38,744)	\$ 2,698,345	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	4	5	6	7	8	9	
		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 9,788,696	\$ 376,508		\$ 337,763	\$ (38,744)	\$ 2,698,345	1
2									2
3	Allocation from Home Office					101,956	101,956		3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 9,788,696	\$ 376,508		\$ 439,719	\$ 63,212	\$ 2,698,345	34

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

Facility Name & ID Number Villa Scalabrini Nursing & Rehab

0044792

Report Period Beginning:

07/01/2008

Ending:

06/30/2009

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	\$ 886,078	\$ 132,597	\$ 132,597	\$	5-20	\$ 324,045	71
72	Current Year Purchases	289,739	20,684	20,684		3-20	20,684	72
73	Fully Depreciated Assets	1,853,924					1,853,924	73
74	Allocation from Home Office			47,944	47,944			74
75	TOTALS	\$ 3,029,741	\$ 153,281	\$ 201,225	\$ 47,944		\$ 2,198,653	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 14,318,437	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 529,789	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 640,944	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 111,156	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,896,998	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	N/A	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. YES NO

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

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

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

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

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 51,006 Description: Please Refer to Attached Page 14A

(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.	<u>/2010</u>	\$ _____
13.	<u>/2011</u>	\$ _____
14.	<u>/2012</u>	\$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Provider Number: 0044792

FYE: 06/30/09

Attachment to Schedule XII, Line 16- Equipment Rental Cost

<u>Equipment</u>	<u>Amount</u>
Copiers	18,545
Postage	1,061
MEDICAL EQUIPMENT	1,085
SPECIAL BEDS	30,315
Total Equipment Lease Exp	<u>51,006</u>

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>
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B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		1	2	3	4
		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		2393 hrs	\$ 99,415	363	\$ 23,704		2,756	\$ 123,119	1
2	Licensed Speech and Language Development Therapist		894 hrs	45,090	41	2,699		935	47,789	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		4627 hrs	204,116	368	22,861		4,995	226,977	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				1,661,764		1,661,764	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			\$ 348,621	772	\$ 49,264	\$ 1,661,764	8,686	\$ 2,059,649	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.

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	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 1,020,669	\$ 1,020,669	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 989,842)	1,310,927	1,310,927	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	8,505	8,505	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,340,101	\$ 2,340,101	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	1,500,000	1,500,000	13
14	Buildings, at Historical Cost	9,773,575	7,510,695	14
15	Leasehold Improvements, at Historical Cost	23,837	2,278,001	15
16	Equipment, at Historical Cost	3,450,810	3,029,741	16
17	Accumulated Depreciation (book methods)	(5,126,447)	(4,896,998)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	78,000	78,000	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(75,400)	(75,400)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Contribution</u>	4,718	4,718	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 9,629,093	\$ 9,428,757	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 11,969,194	\$ 11,768,858	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 259,265	\$ 259,265	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Due to Relaed Org.</u>	(839,693)	(1,040,029)	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ (580,428)	\$ (780,764)	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)	\$ (580,428)	\$ (780,764)	46
47	TOTAL EQUITY(page 18, line 24)	\$ 12,549,622	\$ 12,549,622	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 11,969,194	\$ 11,768,858	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 11,347,220	1
2	Restatements (describe):		2
3	Prior Period Adjustment	111,324	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 11,458,544	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,007,116	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) Equity Transfer	83,962	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 1,091,078	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)	\$ 12,549,622	24 *

* This must agree with page 17, line 47.

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	\$ 24,477,736	1
2	Discounts and Allowances for all Levels	(6,560,065)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 17,917,671	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	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	11,475	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 11,475	23
	D. Non-Operating Revenue		
24	Contributions	2,965	24
25	Interest and Other Investment Income***	3,943	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 6,908	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Net Assets Released and Other	67,742	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 67,742	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 18,003,796	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,830,223	31
32	Health Care	6,927,498	32
33	General Administration	4,876,747	33
	B. Capital Expense		
34	Ownership	529,788	34
	C. Ancillary Expense		
35	Special Cost Centers	1,661,764	35
36	Provider Participation Fee	134,685	36
	D. Other Expenses (specify):		
37	Financial Audit Adjustments - employee benefits	30,630	37
38	Financial Audit Adjustments - Admin Supplies	5,345	38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 16,996,680	40
41	Income before Income Taxes (line 30 minus line 40)**	1,007,116	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,007,116	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.

Villa Scalabrini Nursing and Rehab Center

Medicaid Provider Number: 0044792

FYE 6/30/2009

Attchment to Line 28, Schedule XVII - Other Revenue

<u>Description</u>	<u>Amount</u>	<u>Remark</u>
Net Assets Released from restrictions	21,929	Not an income - not subject to offset
Rental Intercompany	16,614	Not subject to offset
Admin - Other Revenue	16,826	Offset on Page 5A, Line 3
Laundry _ Private Patient Revenue	12,373	Pvt Pt. Not subject to offset
Total - Other Revenue	<u>67,742</u>	

Facility Name & ID Number Villa Scalabrini Nursing & Rehab

0044792

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	1,824	2,100	\$ 97,253	\$ 46.31	1
2	Assistant Director of Nursing	1,888	2,120	84,611	39.91	2
3	Registered Nurses	62,121	70,567	2,429,387	34.43	3
4	Licensed Practical Nurses	12,600	14,545	362,166	24.90	4
5	CNAs & Orderlies	140,862	157,546	2,090,532	13.27	5
6	CNA Trainees					6
7	Licensed Therapist	7,624	8,261	366,776	44.40	7
8	Rehab/Therapy Aides	11,095	12,300	225,859	18.36	8
9	Activity Director					9
10	Activity Assistants	12,817	13,891	171,730	12.36	10
11	Social Service Workers	958	1,089	28,938	26.57	11
12	Dietician	3,824	4,091	85,816	20.98	12
13	Food Service Supervisor	1,912	2,288	57,072	24.94	13
14	Head Cook	9,435	10,672	151,881	14.23	14
15	Cook Helpers/Assistants	26,298	28,864	296,876	10.29	15
16	Dishwashers					16
17	Maintenance Workers	7,833	8,718	166,718	19.12	17
18	Housekeepers	24,396	27,047	308,216	11.40	18
19	Laundry	11,258	12,867	135,935	10.56	19
20	Administrator					20
21	Assistant Administrator	1,824	2,120	49,594	23.39	21
22	Other Administrative	21,019	23,927	390,583	16.32	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: MDS Care Plan	5,011	5,668	189,867	33.50	32
33	Other(specify) <u>Spiritual Svc</u>	10,261	10,346	226,631	21.91	33
34	TOTAL (lines 1 - 33)	374,860	419,027	\$ 7,916,441 *	\$ 18.89	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant			35	
36	Medical Director	Monthly	14,400	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 14,400		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	N/A			50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

Facility Name & ID Number Villa Scalabrini Nursing & Rehab

0044792

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. Life Service Network of Illinois dues -\$3,205
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 11.5 Yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 23,621 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.
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 134,685
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. \$ None Has any meal income been offset against related costs? Yes Indicate the amount. \$ 11,475
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 0
- d. Have vehicle usage logs been maintained? Adequate records have been maintained
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: KPMG, LLP
- (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