



Facility Name & ID Number St Vincent's Home

# 0036723 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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 07-01-2010

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>99</u>	Skilled (SNF)	<u>90</u>	<u>34,506</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>99</u>	TOTALS	<u>90</u>	<u>34,506</u>	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	4 Private Pay	Other	Total	
8	SNF	<u>8,580</u>	<u>3,449</u>	<u>4,071</u>	<u>16,100</u>	8
9	SNF/PED					9
10	ICF		<u>7,610</u>		<u>7,610</u>	10
11	ICF/DD	<u>365</u>			<u>365</u>	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>8,945</u>	<u>11,059</u>	<u>4,071</u>	<u>24,075</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 69.77%

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 10/01/90

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 10/01/90 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 89 and days of care provided 4,071

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: 2010 Fiscal Year: \_\_\_\_\_

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

Facility Name & ID Number St Vincent's Home # 0036723 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

**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
	<b>A. General Services</b>										
1	Dietary	201,466	15,185	10,103	226,754		226,754		226,754		1
2	Food Purchase		159,809		159,809	(1,424)	158,385	(9,936)	148,449		2
3	Housekeeping	116,662	17,616		134,278		134,278		134,278		3
4	Laundry	72,043	7,529	338	79,910		79,910		79,910		4
5	Heat and Other Utilities			117,905	117,905		117,905		117,905		5
6	Maintenance	48,567	14,982	63,062	126,611	16,327	142,938	(20)	142,918		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	438,738	215,121	191,408	845,267	14,903	860,170	(9,956)	850,214		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			9,000	9,000		9,000		9,000		9
10	Nursing and Medical Records	1,416,785	110,500	480	1,527,765		1,527,765	(2,059)	1,525,706		10
10a	Therapy		4,353	398,698	403,051		403,051		403,051		10a
11	Activities	57,955	6,654	28,653	93,262		93,262		93,262		11
12	Social Services	76,090	18	1,981	78,089		78,089		78,089		12
13	CNA Training										13
14	Program Transportation		5,420		5,420		5,420	(1,957)	3,463		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,550,830	126,945	438,812	2,116,587		2,116,587	(4,016)	2,112,571		16
	<b>C. General Administration</b>										
17	Administrative	69,542			69,542		69,542	44,000	113,542		17
18	Directors Fees										18
19	Professional Services			148,438	148,438		148,438	(81,809)	66,629		19
20	Dues, Fees, Subscriptions & Promotions			44,145	44,145		44,145	(27,146)	16,999		20
21	Clerical & General Office Expenses	87,843	35,379	15,111	138,333	(16,327)	122,006	37	122,043		21
22	Employee Benefits & Payroll Taxes			285,392	285,392	1,424	286,816		286,816		22
23	Inservice Training & Education			42,761	42,761		42,761		42,761		23
24	Travel and Seminar			8,239	8,239		8,239		8,239		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			54,932	54,932		54,932		54,932		26
27	Other (specify):* <b>Sales Tax</b>			2,479	2,479		2,479	(2,479)			27
28	<b>TOTAL General Administration</b>	157,385	35,379	601,497	794,261	(14,903)	779,358	(67,397)	711,961		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,146,953	377,445	1,231,717	3,756,115		3,756,115	(81,369)	3,674,746		29

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

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

Facility Name &amp; ID Number

St Vincent's Home

#0036723

Report Period Beginning:

01/01/2010

Ending:

12/31/2010

## 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	
	<b>D. Ownership</b>											
30	Depreciation			132,183	132,183		132,183		132,183			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			107,824	107,824		107,824	(5,370)	102,454			32
33	Real Estate Taxes			69,493	69,493		69,493		69,493			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			190	190		190		190			35
36	Other (specify):* <b>Income Tax</b>			2,741	2,741		2,741	(2,741)				36
37	<b>TOTAL Ownership</b>			312,431	312,431		312,431	(8,111)	304,320			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		176,281		176,281		176,281		176,281			39
40	Barber and Beauty Shops		1,286	12,877	14,163		14,163		14,163			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			51,305	51,305		51,305		51,305			42
43	Other (specify):* <b>Bad Debts</b>			94,628	94,628		94,628	(94,628)				43
44	<b>TOTAL Special Cost Centers</b>		177,567	158,810	336,377		336,377	(94,628)	241,749			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,146,953	555,012	1,702,958	4,404,923		4,404,923	(184,108)	4,220,815			45

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

**VI. ADJUSTMENT DETAIL**

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

		1	2	3	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(9,202)	2		4
5	Telephone, TV & Radio in Resident Rooms	(20)	6		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients	(2,059)	10		7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(5,370)	32		10
11	Discounts, Allowances, Rebates & Refunds	(734)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,479)	27		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions	(43,400)	19		15
16	Personal Expenses (Including Transportation)	(1,957)	14		16
17	Non-Care Related Fees	(6,000)	17		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(310)	20		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(94,628)	43		24
25	Fund Raising, Advertising and Promotional	(26,878)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(2,741)	36		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (195,778)		\$	30

**B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)**

		1	2	
		<b>Amount</b>	<b>Reference</b>	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	11,670		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 11,670		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (184,108)		37

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

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

		1	2	3	4	
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

**BHF USE ONLY**

48		49		50		51		52	
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St Vincent's Home

ID# 0036723

Report Period Beginning: 01/01/2010

Ending: 12/31/2010

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

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number St Vincent's Home# 0036723

Report Period Beginning:

01/01/2010

Ending:

12/31/2010

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(9,936)	0	0	0	0	0	0	0	0	0	0	(9,936)	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	(20)	0	0	0	0	0	0	0	0	0	0	(20)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(9,956)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(9,956)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(2,059)	0	0	0	0	0	0	0	0	0	0	(2,059)	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	(1,957)	0	0	0	0	0	0	0	0	0	0	(1,957)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>(4,016)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(4,016)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	(6,000)	50,000	0	0	0	0	0	0	0	0	0	44,000	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(43,400)	(38,409)	0	0	0	0	0	0	0	0	0	(81,809)	19
20	Fees, Subscriptions & Promotions	(27,188)	42	0	0	0	0	0	0	0	0	0	(27,146)	20
21	Clerical & General Office Expenses	0	37	0	0	0	0	0	0	0	0	0	37	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(2,479)	0	0	0	0	0	0	0	0	0	0	(2,479)	27
28	<b>TOTAL General Administration</b>	<b>(79,067)</b>	<b>11,670</b>	<b>0</b>	<b>(67,397)</b>	<b>28</b>								
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(93,039)</b>	<b>11,670</b>	<b>0</b>	<b>(81,369)</b>	<b>29</b>								

## STATE OF ILLINOIS

Facility Name & ID Number St Vincent's Home# 0036723

Report Period Beginning:

01/01/2010 Ending:

Summary B

12/31/2010

## 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)	
	<b>D. Ownership</b>													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(5,370)	0	0	0	0	0	0	0	0	0	0	(5,370)	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):*	(2,741)	0	0	0	0	0	0	0	0	0	0	(2,741)	36
37	<b>TOTAL Ownership</b>	<b>(8,111)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(8,111)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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):*	(94,628)	0	0	0	0	0	0	0	0	0	0	(94,628)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(94,628)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(94,628)</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(195,778)</b>	<b>11,670</b>	<b>0</b>	<b>(184,108)</b>	<b>45</b>								

**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
Carlyle Healthcare Inc.	100	Carlyle Healthcare Inc.	Carlyle	WDM Health Svcs	Quincy	Management
		Clinto Manor	New Baden			

**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	19 Management	\$ 82,000	WDM Health Services Inc.		\$ 41,605	\$ (40,395)	1
2	V	19 Accounting				1,955	1,955	2
3	V	19 Legal				31	31	3
4	V	21 Office Supplies				37	37	4
5	V	20 Fees				42	42	5
6	V							6
7	V							7
8	V							8
9	V	17 Officer Salary		Carlyle Healthcare	100.00%	50,000	50,000	9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 82,000			\$ 93,670	\$ * 11,670	14

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

Facility Name &amp; ID Number

St Vincent's Home

# 0036723

Report Period Beginning:

01/01/2010

Ending:

12/31/2010

## 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	Dorothy Messick	President	St. Vincents			10	20.00		\$		1
2	Ann Reis	Secretary	St. Vincents			5	10.00				2
3	Sue Gray	Treasurer	St. Vincents			5	10.00				3
4											4
5	Dorothy Messick	President	Carlyle Healthcare	46.00	100,000	10	20.00	Wages	50,000	17-3	5
6	Ann Reis	Secretary	Carlyle Healthcare	27.00		5	10.00				6
7	Sue Gray	Treasurer	Carlyle Healthcare	27.00		5	10.00				7
8											8
9											9
10	Ann Reis		Clinton Manor			2	4.00				10
11	WDM Health Services Inc.										11
12	Carlyle Healthcare owns 100% of St. Vincents Hpme Inc.										12
13								TOTAL	\$ 50,000		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 Vincent's Home # 0036723 Report Period Beginning: 01/01/2010 Ending: 2/31/2010

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 WDM Health Services Inc.  
 Street Address 1900 Harrison  
 City / State / Zip Code Quincy, IL 62301  
 Phone Number ( 217-228-1950  
 Fax Number ( 217-222-6053

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	19	Management Fees	Patient Days	57,866	2	\$ 100,000	\$ 24,075	\$ 41,605	1
2	19	Accounting	Patient Days	57,866	2	4,700	24,075	1,955	2
3	19	Office Supplies	Patient Days	57,866	2	75	24,075	31	3
4	19	Legal	Patient Days	57,866	2	90	24,075	37	4
5	20	Fees	Patient Days	57,866	2	100	24,075	42	5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 104,965	\$ 100,000	\$ 43,670	25

Facility Name & ID Number

St Vincent's Home

# 0036723

Report Period Beginning:

01/01/2010

Ending:

12/31/2010

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

1	2	3	4	5	6	7	8	9	10										
										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			
<b>A. Directly Facility Related</b>																			
<b>Long-Term</b>																			
1	First Bankers Trust		X	Mortgage	\$18,368.29	04/23/07	\$ 3,500,000	\$ 2,401,980	05/20/11	5.2500	\$ 93,824	1							
2	First Bankers Trust		X	2nd Mortgage	\$1,413.31	11/17/08	200,000	188,275	11/17/13	5.7500	10,212	2							
3												3							
4												4							
5												5							
<b>Working Capital</b>																			
6	First Bankers Trust		X	Line of Credit		11/17/10	75,000	21,612	11/17/11	5.5000	3,788	6							
7												7							
8												8							
9	<b>TOTAL Facility Related</b>				\$19,781.60		\$ 3,775,000	\$ 2,611,867			\$ 107,824	9							
<b>B. Non-Facility Related*</b>																			
10	Investment Interest		X								(5,370)	10							
11												11							
12												12							
13												13							
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ (5,370)	14							
15	<b>TOTALS (line 9+line14)</b>						\$ 3,775,000	\$ 2,611,867			\$ 102,454	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.)

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

**B. Real Estate Taxes**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>			
1. Real Estate Tax accrual used on 2009 report.		\$	<b>(30,767)</b>		<b>1</b>
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.)		\$	<b>2009 69493</b>		<b>2</b>
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>100,260</b>		<b>3</b>
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>(30,767)</b>		<b>4</b>
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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$			<b>5</b>
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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$			<b>6</b>
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>*69493</b>		<b>7</b>
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2005	<u>37,558</u>	<b>8</b>	<b>FOR BHF USE ONLY</b>	
	2006	<u>38,858</u>	<b>9</b>	<b>13</b>	FROM R. E. TAX STATEMENT FOR 2009 \$
	2007	<u>32,858</u>	<b>10</b>		
	2008	<u>72,555</u>	<b>11</b>	<b>14</b>	PLUS APPEAL COST FROM LINE 5 \$
	2009	<u>69,493</u>	<b>12</b>		
* The 1998 addition had a property tax Abatement for 10 years do to the fact we are in an enterprise zone. We are in the process at the state level for appealing those taxes as the the appraisal value is less.				<b>15</b>	LESS REFUND FROM LINE 6 \$
				<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION \$

**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.**



Facility Name & ID Number St Vincent's Home

# 0036723

Report Period Beginning:

01/01/2010 Ending:

12/31/2010

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 38,109 B. General Construction Type: Exterior Brick Frame Steel, concrete Number of Stories 2

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).

1 Community Center

10 Assisted Living Units

12 Duplexes or 24 cottages for Independent living

No Expenses are in schedule V as they are in separate divisions

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>Nursing Home</u>	<u>114,177</u>	<u>1990</u>	<u>\$ 61,500</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<b>114,177</b>		<b>\$ 61,500</b>	<b>3</b>

**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	67		1990	1976	\$ 963,000	\$ 32,123	30	\$ 32,123	\$	\$ 647,128	4
5	23		1998	1998	878,056	31,646	30	31,646		379,179	5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	LAUNDRY ROOM		1999		68,109						9
10	GLASS ENCLOSER		1990		2,972	124	20	124		3,972	10
11	DINNING ROOM ADDITION		1991		86,996	4,349	20	4,349		85,546	11
12	GARAGE		1991		35,000					35,000	12
13	LAND IMPROVEMENTS		1991		13,130					13,130	13
14	CONCRETE DRVWY LOT 1		1993		10,580					10,580	14
15	FIREWALL		1993		1,808	91	20	91		1,626	15
16	CONCRETE DRVWY LOT 2		1997		83,961	5,638	15	5,638		74,261	16
17	NEW ROOF		1997		141,503	4,733	30	4,733		61,429	17
18	LANDSCAPING		1997		10,358	697	15	697		9,022	18
19	ROOFTOP A/C UNITS		1997		6,995					6,995	19
20	HANDRAILS		1998		11,165	751	15	751		9,662	20
21	WALKIN FREEZOR		1998		10,485					10,485	21
22	REMODELING HALLWAYS		1998		26,569					26,569	22
23	FIRE DAMPERS		1999		7,122					7,122	23
24	8 PATIENT ROOM REMODELING		1999		11,018	740	15	740		8,118	24
25	LEVEL BUILDING		2000		74,150	3,743	20	3,743		39,526	25
26	DOORS CLOSERS,NEW VENTILATION, ELECTRICAL		2000		15,450	1,039	15	1,039			26
27	RAILING		2000		2,997					2,997	27
28	WATER HEATER		2000		4,851					4,851	28
29	LAND IMPROVEMENTS		2001		4,522	304	15	304		2,828	29
30	NEW KITCHEN		2001		55,641	3,662	15	3,662		11,064	30
31	A/C COMPRESSOR		2002		5,121	359	8	359		5,121	31
32	SMOKE DECTORS		2002		2,562	243	8	243		2,562	32
33	GENERATOR		2002		4,902	517	8	517		4,902	33
34	NEW HOT/COLD WATER LINES 100/200 WINGS		2005		29,851	995	30	995		5,141	34
35	LANDSCSPING/PARKING LOT LIGHTS		2006		55,446	2,789	20	2,789		11,055	35
36	ROOF HTG/AC		2008		3,976	265	15	265		751	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

XI. OWNERSHIP COSTS (continued)

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

1	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 Emergency Wiring	2009	\$ 6,400	\$ 320	20	\$ 320	\$	\$ 428	37
38 Dietary A/C	2010	342	342	8	342		342	38
39 500 Wing Zone Control	2010	15,512	517	15	517		517	39
40 5 Ton A/C	2010	7,319	325	15	325		325	40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70 TOTAL (lines 4 thru 69)		\$ 2,657,869	\$ 96,312		\$ 96,312	\$	\$ 1,482,234	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 259,369	\$ 30,946	\$ 30,946	\$	8	\$ 178,935	71
72	Current Year Purchases	113,731	2,525	2,525		8	2,525	72
73	Fully Depreciated Assets	97,806					97,806	73
74								74
75	TOTALS	\$ 470,906	\$ 33,471	\$ 33,471	\$		\$ 279,266	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	Facility	1998 Dodge Stratus	2005	\$ 4,000	\$	\$	\$		\$ 4,000	76
77	Facility	1994 GMC truck /plow	1999	12,000					12,000	77
78	Facility	2000 Chev van/lift	2000	40,067					40,067	78
79	Facility	2000 GMC truck/plow	2009	12,000	2,400	2,400		5	3,600	79
80	TOTALS			\$ 68,067	\$ 2,400	\$ 2,400	\$		\$ 59,667	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)	\$ 3,258,342	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 132,183	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 132,183	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,821,167	85

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

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

G. Construction-in-Progress

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

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

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

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: \_\_\_\_\_

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

If NO, see instructions.  YES  NO

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

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

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

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

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

15. Is Movable equipment rental included in building rental? \_\_\_\_\_

YES  NO

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

**C. Vehicle Rental (See instructions.)**

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

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending Annual Rent

12. \_\_\_\_\_ /2011 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2012 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2013 \$ \_\_\_\_\_

\* 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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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)	
<b>TOTAL TRAINED</b>	

- (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-3	hrs	\$		\$ 161,217	\$		\$ 161,217	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs			31,027			31,027	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs			206,454			206,454	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				176,281		176,281	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	<b>TOTAL</b>			\$		\$ 398,698	\$ 176,281		\$ 574,979	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 Vincent's Home# 0036723Report Period Beginning: 01/01/2010Ending: 12/31/2010

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2010

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 417,796	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	698,120		3
4	Supply Inventory (priced at <u>FIFO</u> )	18,663		4
5	Short-Term Investments			5
6	Prepaid Insurance	40,707		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,175,286	\$	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	127,282		13
14	Buildings, at Historical Cost	4,222,460		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,026,860		16
17	Accumulated Depreciation (book methods)	(2,837,575)		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 (spe <u>Goodwill</u> )	46,126		22
23	Other(specify): <u>CIP</u>	36,278		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 2,621,431	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 3,796,717	\$	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 100,966	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	12,288		29
30	Accrued Salaries Payable	139,336		30
31	Accrued Taxes Payable (excluding real estate taxes)	(29,059)		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	(1,259)		35
<b>Other Current Liabilities(specify):</b>				
36				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 222,272	\$	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable	2,611,868		40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43	<u>Deferred Income Trusts</u>			43
44		195,883		44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 2,807,751	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 3,030,023	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 766,694	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 3,796,717	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>436,003</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>436,003</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>65,167</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe) <b>Other Divisions</b>	<b>15,524</b>	<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>80,691</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>	<b>Inter company transfer</b>	<b>250,000</b>	<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$ <b>250,000</b>	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>766,694</b>	<b>24</b> *

\* This must agree with page 17, line 47.

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**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 4,202,752	1
2	Discounts and Allowances for all Levels	8,280	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 4,211,032</b>	<b>3</b>
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	149,608	6
7	Oxygen	6,335	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 155,943</b>	<b>8</b>
<b>C. Other Operating Revenue</b>			
9	Payments for Education	752	9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	1,300	12
13	Barber and Beauty Care	11,858	13
14	Non-Patient Meals	9,202	14
15	Telephone, Television and Radio	20	15
16	Rental of Facility Space		16
17	Sale of Drugs	38,580	17
18	Sale of Supplies to Non-Patients	2,059	18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	3,472	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 67,243</b>	<b>23</b>
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	5,370	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 5,370</b>	<b>26</b>
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	rebates	734	28
28a	see attached list	29,769	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 30,503</b>	<b>29</b>
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 4,470,091</b>	<b>30</b>

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	845,267	31
32	Health Care	2,292,868	32
33	General Administration	794,261	33
<b>B. Capital Expense</b>			
34	Ownership	312,431	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	108,791	35
36	Provider Participation Fee	51,305	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 4,404,923</b>	<b>40</b>
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>65,168</b>	<b>41</b>
42	<b>Income Taxes</b>		<b>42</b>
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ 65,168</b>	<b>43</b>

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

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

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

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

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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	1,924	2,088	\$ 57,501	\$ 27.54	1
2	Assistant Director of Nursing	1,944	2,088	44,319	21.23	2
3	Registered Nurses	11,963	12,807	272,508	21.28	3
4	Licensed Practical Nurses	23,457	25,136	405,480	16.13	4
5	CNAs & Orderlies	55,995	58,626	608,518	10.38	5
6	CNA Trainees	2,727	2,898	28,459	9.82	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,976	2,088	23,247	11.13	9
10	Activity Assistants	3,926	4,117	34,708	8.43	10
11	Social Service Workers	4,828	5,099	76,090	14.92	11
12	Dietician					12
13	Food Service Supervisor	2,008	2,088	34,084	16.32	13
14	Head Cook					14
15	Cook Helpers/Assistants	13,666	14,474	129,770	8.97	15
16	Dishwashers	4,098	4,434	37,612	8.48	16
17	Maintenance Workers	4,046	4,394	48,567	11.05	17
18	Housekeepers	11,252	12,238	116,662	9.53	18
19	Laundry	7,173	7,787	72,043	9.25	19
20	Administrator	1,992	2,088	69,542	33.31	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,216	7,604	87,843	11.55	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 Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	160,191	170,054	\$ 2,146,953 *	\$ 12.63	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	175	\$ 10,103	1-3	35
36	Medical Director		9,000	9-3	36
37	Medical Records Consultant	16	480	10-3	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	48	1,981	12-3	45
46	Other(specify) <u>Religious</u>		28,653	11-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	239	\$ 50,217		49

C. CONTRACT NURSES

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





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**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. IHCA 3560
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? 310
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 8 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 12,356 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. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 51,305  
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? Yes 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. \$ 1,424 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 9,202
- (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. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? 100  
d. Have vehicle usage logs been maintained? No  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?  
**g. Does the facility transport residents to and from day training? N**  
**Indicate the amount of income earned from providing such transportation during this reporting period.** \$ \_\_\_\_\_
- (17) Has an audit been performed by an independent certified public accounting firm? N  
Firm Name: \_\_\_\_\_
- (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? \_\_\_\_\_  
Attach invoices and a summary of services for all architect and appraisal fees.