

		FOR OHF USE				

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**2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)**

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p>I. IDPH Facility ID Number: <u>0005520</u></p> <p>Facility Name: <u>MOUNT ST JOSEPH</u></p> <p>Address: <u>24955 N HIGHWAY 12</u> <u>LAKE ZURICH</u> <u>60047</u> <small>Number City Zip Code</small></p> <p>County: <u>LAKE</u></p> <p>Telephone Number: <u>847-438-5050</u> Fax # <u>847-438-1561</u></p> <p>IDPA ID Number: <u>36-2639774</u></p> <p>Date of Initial License for Current Owners: <u>1947</u></p> <p>Type of Ownership:</p> <table style="width:100%"> <tr> <td><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input checked="" type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>DON LASCO</u> Telephone Number: <u>() () ()</u></p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>7/1/2000</u> to <u>6/30/2001</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%"> <tr> <td style="width:20%;">Officer or Administrator of Provider</td> <td>(Signed) _____ (Date) _____</td> </tr> <tr> <td></td> <td>(Type or Print Name) <u>SISTER NOREEN FRANZINA</u></td> </tr> <tr> <td></td> <td>(Title) <u>SUPERIOR</u></td> </tr> <tr> <td>Paid Preparer</td> <td>(Signed) _____ (Date) _____</td> </tr> <tr> <td></td> <td>(Print Name and Title) _____</td> </tr> <tr> <td></td> <td>(Firm Name & Address) _____</td> </tr> <tr> <td></td> <td>(Telephone) <u>() () ()</u> Fax # <u>() () ()</u></td> </tr> </table> <p align="center">MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Date) _____		(Type or Print Name) <u>SISTER NOREEN FRANZINA</u>		(Title) <u>SUPERIOR</u>	Paid Preparer	(Signed) _____ (Date) _____		(Print Name and Title) _____		(Firm Name & Address) _____		(Telephone) <u>() () ()</u> Fax # <u>() () ()</u>
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																					
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	(Firm Name & Address) _____																																						
	(Telephone) <u>() () ()</u> Fax # <u>() () ()</u>																																						

Facility Name & ID Number MOUNT ST JOSEPH

0005520 Report Period Beginning: 7/1/2000 Ending: 6/30/2001

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	132	Intermediate/DD	132	48,180	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	132	TOTALS	132	48,180	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		3 Public Aid Recipient	4 Private Pay	Other		
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	40,612	988		41,600	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	40,612	988		41,600	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.34%

D. How many bed-hold days during this year were paid by Public Aid? 1,874 (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 1947

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

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

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 6/30/01 Fiscal Year: 6/30/01

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

STATE OF ILLINOIS

Page 3

Facility Name & ID Number

MOUNT ST JOSEPH

0005520

Report Period Beginning:

7/1/2000

Ending:

6/30/2001

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 OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	170,331	176	9,733	180,240		180,240	(18,240)	162,000		1
2	Food Purchase		163,097		163,097		163,097	(16,097)	147,000		2
3	Housekeeping	315,674	14,662		330,336		330,336		330,336		3
4	Laundry	37,445	2,908		40,353		40,353		40,353		4
5	Heat and Other Utilities			226,892	226,892		226,892	(11,345)	215,547		5
6	Maintenance	59,804	39,455	299,950	399,209		399,209		399,209		6
7	Other (specify):* FARM	31,890		787	32,677		32,677	(32,677)			7
8	TOTAL General Services	615,144	220,298	537,362	1,372,804		1,372,804	(78,359)	1,294,445		8
	B. Health Care and Programs										
9	Medical Director	30,344			30,344		30,344		30,344		9
10	Nursing and Medical Records	2,056,213	52,405	14,265	2,122,883	(18,855)	2,104,028		2,104,028		10
10a	Therapy	234,377	2,832	11,114	248,323		248,323	(6,000)	242,323		10a
11	Activities										11
12	Social Services	163,137	3,153	2,040	168,330		168,330		168,330		12
13	Nurse Aide Training					18,855	18,855		18,855		13
14	Program Transportation										14
15	Other (specify):* DAY TRAINING	242,752	13,372	95,444	351,568		351,568	(351,568)			15
16	TOTAL Health Care and Programs	2,726,823	71,762	122,863	2,921,448		2,921,448	(357,568)	2,563,880		16
	C. General Administration										
17	Administrative	121,389	5,609	33,400	160,398		160,398		160,398		17
18	Directors Fees										18
19	Professional Services			72,419	72,419		72,419		72,419		19
20	Dues, Fees, Subscriptions & Promotions			18,829	18,829		18,829		18,829		20
21	Clerical & General Office Expenses	217,964	25,652		243,616	(2,640)	240,976		240,976		21
22	Employee Benefits & Payroll Taxes			601,221	601,221		601,221	(17,295)	583,926		22
23	Inservice Training & Education										23
24	Travel and Seminar			219	219		219		219		24
25	Other Admin. Staff Transportation			10,726	10,726		10,726		10,726		25
26	Insurance-Prop.Liab.Malpractice			104,901	104,901		104,901		104,901		26
27	Other (specify):*										27
28	TOTAL General Administration	339,353	31,261	841,715	1,212,329	(2,640)	1,209,689	(17,295)	1,192,394		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,681,320	323,321	1,501,940	5,506,581	(2,640)	5,503,941	(453,222)	5,050,719		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

MOUNT ST JOSEPH

#0005520

Report Period Beginning:

7/1/2000

Ending:

6/30/2001

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			207,727	207,727		207,727	158,961	366,688			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			180,000	180,000		180,000	(219,600)	(39,600)			34
35	Rent-Equipment & Vehicles					2,640	2,640		2,640			35
36	Other (specify):*											36
37	TOTAL Ownership			387,727	387,727	2,640	390,367	(60,639)	329,728			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			3,512	3,512		3,512		3,512			41
42	Provider Participation Fee			282,812	282,812		282,812		282,812			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			286,324	286,324		286,324		286,324			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,681,320	323,321	2,175,991	6,180,632		6,180,632	(513,861)	5,666,771			45

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

Facility Name & ID Number MOUNT ST JOSEPH

0005520

Report Period Beginning: 7/1/2000

Ending: 6/30/2001

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(34,337)	L1&L2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space	(39,600)	L34		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(68,146)	L30		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(6,000)	L10a		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals	(351,568)	L15		23
24	Bad Debt	(14,764)	L22		24
25	Fund Raising, Advertising and Promotional	(2,531)	L22		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(32,677)	L7		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(11,345)	L5		28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (560,968)		\$	30

OHF USE ONLY					
48		49	50	51	52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	47,107	VIII14	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 47,107		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (513,861)		37

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

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

		1	2	3	4
		Yes	No	Amount	Reference
38	Medically Necessary Transport.			\$	38
39					39
40	Gift and Coffee Shops	X		3,512	L41
41	Barber and Beauty Shops				41
42	Laboratory and Radiology				42
43	Prescription Drugs				43
44	Exceptional Care Program				44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	TOTAL (C): (sum of lines 38-46)			\$ 3,512	47

MOUNT ST JOSEPHID# 0005520Report Period Beginning: 7/1/2000Ending: 6/30/2001

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	DEPRECIATION	(68,146)	L30	14
15				15
16				16
17	PRIEST STIPEND	(6,000)	L10a	17
18				18
19				19
20				20
21				21
22				22
23	DAY TRAINING	(351,568)	L15	23
24	DAY TRAINING TAX	(14,764)	L22	24
25	FARM TAX	(2,531)	L22	25
26	FARM	(32,677)	L7	26
27				27
28	UTILITIES	(11,345)	L5	28
29				29
30	SUBTOTAL (A):	(560,968)		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			49

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
DAUGHTERS OF ST. MARY OF PROVIDENCE	100					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
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	34 RENT	\$ 180,000	DAUGHTERS OF ST. MARY	100.00%	\$	(180,000)	1
2	V	30 DEPRECIATION		DAUGHTERS OF ST. MARY	100.00%	227,107	227,107	2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 180,000			\$ 227,107	\$ * 47,107	14

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

Facility Name & ID Number MOUNT ST JOSEPH # 0005520 Report Period Beginning: 7/1/2000 Ending: 6/30/2001

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	SR. NOREEN FRANZINA	TREASURER	ADMINISTRATOR			84	100.00	SALARY	\$ 58,119	L17C1	1
2	SR. JANET KOSMAN	SECRETARY	ADMINISTRATOR			84	100.00	SALARY	17,170	L17C1	2
3	SR. JANET KOSMAN	SECRETARY	ADMINISTRATOR						21,823	L21C1	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 97,112		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 MOUNT ST JOSEPH # 0005520 Report Period Beginning: 7/1/2000 Ending: 3/30/2001

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1 Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							\$	\$			\$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						\$	\$			\$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$	\$			\$	15

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

(See instructions.)

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

(See instructions.)

Facility Name & ID Number **MOUNT ST JOSEPH**# **0005520** Report Period Beginning: **7/1/2000** Ending: **6/30/2001****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.																	
1.	Real Estate Tax accrual used on 2000 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 2001 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 19 _____ 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:		1996	8	<table border="1"> <tr> <td colspan="2">FOR OHF USE ONLY</td> </tr> <tr> <td>13</td> <td>FROM R. E. TAX STATEMENT FOR 2000 \$</td> <td>13</td> </tr> <tr> <td>14</td> <td>PLUS APPEAL COST FROM LINE 5 \$</td> <td>14</td> </tr> <tr> <td>15</td> <td>LESS REFUND FROM LINE 6 \$</td> <td>15</td> </tr> <tr> <td>16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$</td> <td>16</td> </tr> </table>		FOR OHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2000 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
FOR OHF USE ONLY																			
13	FROM R. E. TAX STATEMENT FOR 2000 \$	13																	
14	PLUS APPEAL COST FROM LINE 5 \$	14																	
15	LESS REFUND FROM LINE 6 \$	15																	
16	AMOUNT TO USE FOR RATE CALCULATION \$	16																	
	1997	9																	
	1998	10																	
	1999	11																	
	2000	12																	

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:** 2000 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 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 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 Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME MOUNT ST JOSEPH COUNTY LAKE

FACILITY IDPH LICENSE NUMBER 0005520

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 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 2000.

(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. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number MOUNT ST JOSEPH# 0005520 Report Period Beginning:7/1/2000 Ending:6/30/2001**X. BUILDING AND GENERAL INFORMATION:**A. Square Feet: 147,565 B. General Construction Type: Exterior BRICK Frame BRICK Number of Stories 2C. 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, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

DEVELOPMENTAL TRAINING 1010 SQ.FEETF. 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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>HOME & FARM</u>	<u>160 ACRES</u>	<u>1935</u>	<u>\$ 8,000</u>	<u>1</u>
2		<u>OR 6,969,600 SQ. FEET</u>			<u>2</u>
3	TOTALS	#VALUE!		\$ 8,000	3

Facility Name & ID Number MOUNT ST JOSEPH

0005520

Report Period Beginning:

7/1/2000

Ending:

6/30/2001

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 OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	132		1969	\$ 5,007,009	\$ 146,096	30.5	\$ 146,096	\$	\$ 4,730,783	4
5										5
6			1990	2,361,653	78,720	30	78,720		905,282	6
7			1990	68,729	2,290	30	2,290		26,335	7
8										8
Improvement Type**										
9	LAND IMPROVEMENT PRIOR YEARS			267,135	16,560		16,560		149,699	9
10										10
11	BUILDING IMPROVEMENT PRIOR YEARS			1,184,133	78,154		78,154		550,489	11
12										12
13										13
14	BUILDING IMPROVEMENT		2000	76,812	5,375		5,375		5,375	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

*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	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			\$	\$		\$	\$	\$		37
38										38
39										39
40										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)		\$ 8,965,471	\$ 327,195		\$ 327,195	\$	\$ 6,367,963		70

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

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	\$ 1,139,094	\$ 35,288	\$ 35,288	\$		\$ 907,093	71
72	Current Year Purchases	9,726	706	706			35,994	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,148,820	\$ 35,994	\$ 35,994	\$		\$ 943,087	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	RESIDENTS TRANSPORT	93 FORD VAN	1993	\$ 34,927	\$ 3,499	\$ 3,499	\$	10	\$ 34,927	76
77										77
78										78
79										79
80	TOTALS			\$ 34,927	\$ 3,499	\$ 3,499	\$		\$ 34,927	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)	\$ 10,157,218	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 366,688	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 366,688	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)	\$ 7,345,977	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	FARM EQUIPMENT	\$ 40,316	\$	\$ 40,316	86
87	VEHICLES	383,110	23,304	260,399	87
88	NON CARE EQUIPMENT	1,052,810	44,842	751,635	88
89					89
90					90
91	TOTALS	\$ 1,476,236	\$ 68,146	\$ 1,052,350	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? YES NO
 If NO, see instructions.

		1 Year Constructed	2 Number of Beds	3 Date of Lease	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

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>/2002</u>	\$ _____
13.	<u>/2003</u>	\$ _____
14.	<u>/2004</u>	\$ _____

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: \$ 2,640 Description: COPY MACHINE

(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

* 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 NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</p> <p><input checked="" type="checkbox"/> YES <input 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. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE <u>40</u></p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE <u>80</u></p>
--	---	---

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)	3,255	5,200		8,455
4 Clinical Wages (b)				
5 In-House Trainer Wages (c)		10,400		10,400
6 Transportation				
7 Contractual Payments				
8 Nurse Aide Competency Tests				
9 TOTALS	\$ 3,255	\$ 15,600	\$	\$ 18,855
10 SUM OF line 9, col. 1 and 2 (e)	\$ 18,855			

- (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 aide 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 aides.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	13
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	13
2. From other facilities (f)	
TOTAL TRAINED	26

- (e) The total amount of Drop-out and Completed Costs for your own aides 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 aides.

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8	
			Units of Service	Cost	Outside Practitioner (other than consultant)		Units	Cost	Total Cost (Col. 3 + 5 + 6)					
					Units	Cost								
1	Licensed Occupational Therapist		hrs	\$				\$					\$	1
2	Licensed Speech and Language Development Therapist		hrs											2
3	Licensed Recreational Therapist		hrs											3
4	Licensed Physical Therapist		hrs											4
5	Physician Care	9/1	visits		30,344									5
6	Dental Care		visits											6
7	Work Related Program		hrs											7
8	Habilitation		hrs											8
9	Pharmacy		# of prescrpts											9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs											10
11	Academic Education		hrs											11
12	Exceptional Care Program													12
13	Other (specify):													13
14	TOTAL			\$	30,344			\$		\$			\$	30,344

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 nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Page 17

Facility Name & ID Number MOUNT ST JOSEPH

0005520

Report Period Beginning: 7/1/2000

Ending:

6/30/2001

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/2001

(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	\$ 766,703	\$ 766,703	1
2 Cash-Patient Deposits	66,512	66,512	2
3 Accounts & Short-Term Notes Receivable-Patients (less allowance)	814,923	814,923	3
4 Supply Inventory (priced at)			4
5 Short-Term Investments	52,541	52,541	5
6 Prepaid Insurance	66,946	66,946	6
7 Other Prepaid Expenses	1,002	1,002	7
8 Accounts Receivable (owners or related parties)			8
9 Other(specify):			9
TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,768,627	\$ 1,768,627	10
B. Long-Term Assets			
11 Long-Term Notes Receivable			11
12 Long-Term Investments			12
13 Land		8,000	13
14 Buildings, at Historical Cost		7,437,391	14
15 Leasehold Improvements, at Historical Cost	1,452,137	1,452,137	15
16 Equipment, at Historical Cost	2,735,926	2,735,926	16
17 Accumulated Depreciation (book methods)	(2,735,926)	(7,345,977)	17
18 Deferred Charges			18
19 Organization & Pre-Operating Costs			19
20 Accumulated Amortization - Organization & Pre-Operating Costs			20
21 Restricted Funds			21
22 Other Long-Term Assets (specify):			22
23 Other(specify):			23
TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,452,137	\$ 4,287,477	24
TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,220,764	\$ 6,056,104	25

	1	2	
	Operating	After Consolidation*	
C. Current Liabilities			
26 Accounts Payable	\$ 347,611	\$ 347,611	26
27 Officer's Accounts Payable			27
28 Accounts Payable-Patient Deposits	66,512	66,512	28
29 Short-Term Notes Payable			29
30 Accrued Salaries Payable	609,020	609,020	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			36
37			37
TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,023,143	\$ 1,023,143	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
TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,023,143	\$ 1,023,143	46
TOTAL EQUITY(page 18, line 24)	\$ 2,197,621	\$ 5,032,961	47
TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,220,764	\$ 6,056,104	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,678,514	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,678,514	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(480,893)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (480,893)	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)	\$ 2,197,621	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	\$ 4,932,684	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,932,684	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	915	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 915	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	1,361	12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	39,600	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)	\$ 40,961	23
D. Non-Operating Revenue			
24	Contributions	288,796	24
25	Interest and Other Investment Income***	42,510	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 331,306	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	DAY TRAINING	393,873	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 393,873	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,699,739	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,372,804	31
32	Health Care	2,921,448	32
33	General Administration	1,209,689	33
B. Capital Expense			
34	Ownership	390,367	34
C. Ancillary Expense			
35	Special Cost Centers	3,512	35
36	Provider Participation Fee	282,812	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,180,632	40
41	Income before Income Taxes (line 30 minus line 40)**	(480,893)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (480,893)	43

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

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

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

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

Facility Name & ID Number MOUNT ST JOSEPH

0005520

Report Period Beginning: 7/1/2000

Ending:

6/30/2001

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	2,661	2,761	\$ 51,900	\$ 18.80	1
2	Assistant Director of Nursing					2
3	Registered Nurses	23,482	23,932	331,461	13.85	3
4	Licensed Practical Nurses	9,329	9,529	121,214	12.72	4
5	Nurse Aides & Orderlies					5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	12,073	12,273	134,389	10.95	9
10	Activity Assistants	12,752	12,902	99,988	7.75	10
11	Social Service Workers	10,626	10,876	163,137	15.00	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	10,801	10,901	103,018	9.45	14
15	Cook Helpers/Assistants	9,872	9,972	67,313	6.75	15
16	Dishwashers					16
17	Maintenance Workers	6,331	6,431	59,804	9.30	17
18	Housekeepers	37,675	38,125	315,674	8.28	18
19	Laundry	4,890	4,940	37,445	7.58	19
20	Administrator	7,112	7,162	104,219	14.55	20
21	Assistant Administrator	1,650	1,675	17,170	10.25	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	18,853	19,153	217,964	11.38	24
25	Vocational Instruction					25
26	Academic Instruction	19,258	19,608	242,752	12.38	26
27	Medical Director	1,760	1,785	30,344	17.00	27
28	Qualified MR Prof. (QMRP)	15,402	15,552	179,158	11.52	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	70,629	72,503	1,318,111	18.18	30
31	Medical Records					31
32	Other Health C: PSYCHOLOGY	3,854	3,906	54,369	13.92	32
33	Other(specify) FARM	3,500	3,524	31,890	9.05	33
34	TOTAL (lines 1 - 33)	282,510	287,510	\$ 3,681,320 *	\$ 12.80	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	184	\$ 9,733	L1C3	35
36	Medical Director				36
37	Medical Records Consultant	105	4,200	L10C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	103	5,449	L10aC3	40
41	Occupational Therapy Consultant	103	5,665	L10aC3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	175	8,723	L10C3	44
45	Social Service Consultant				45
46	Other(specify) PSYCHOLOGIST	2	150	L12C3	46
47	PSYCHIATRIST	13	1,890	L12C3	47
48	PODIATRIST	22	1,342	L10C3	48
49	TOTAL (lines 35 - 48)	707	\$ 37,152		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	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

Facility Name & ID Number MOUNT ST JOSEPH

0005520

Report Period Beginning: 7/1/2000

Ending: 6/30/2001

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? NO
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 5YEARS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 14,505 Line L10
- (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 of Public Aid during this cost report period. \$ 282,812
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 of Public Aid, 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? YES 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. \$ N/A Has any meal income been offset against related costs? _____ Indicate the amount. \$ _____
- (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? YES If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 5,297
- c. What percent of all travel expense relates to transportation of nurses and patients? 10%
- 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? YES
- g. Does the facility transport residents to and from day training? YES**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: DELOITTE & TOUCHE The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? YES If no, please explain. _____
- (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 \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.

PRIOR YEARS		227,859
LAND IMPROVEMENT-PAVING	1998	15,783
ASPHALP WORK		1,640
TOTAL		17,423
PAVING	1999	21,009
PAINT PARKING LOT		844
TOTAL		21,853

LAND IMPROVEMENTS	PRIOR YEARS	
	1993	29,005
	1994	53,489
	1995	44,713
	1996	18,082
	1997	42,570
	TOTAL	227,859
	TOTAL	267,135

BUILDING IMPROVEMENTS		
	1991	74,205
	1992	90,293
	1993	160,181
	1994	178,251
	1995	231,228
	1996	62,875
	1997	71,814
PRIOR YEARS TOTAL		908,847

BUILDING IMPROVEMENTS		
REBUILD EXHAUST MOTOR	Jul-97	4,000
REPAIR BOILER	Jul-97	6,337
AIR CONDITIONER	Aug-97	2,176
LIGHTS	Aug-97	7,430
SIDEWALKS	Aug-97	21,690
PUMPS	Sep-97	5,000
PLUMBING	Sep-97	2,647
LIGHT FIXTURES	Sep-97	14,985
ELECTRICAL	Sep-97	2,250
PAINT LAUNDRY ROOM	Oct-97	1,078
FIRE DAMPER	Oct-97	10,545
ELECTRICAL PLAN	Oct-97	1,744
FIRE DOORS	Nov-97	7,806
PLUMBING	Nov-97	1,027
DRAPES	Nov-97	2,663
ELECTRICAL	Oct-97	1,849
REPAIR FIRE DAMPER	Oct-97	2,290
BOILER REPAIR	Oct-97	3,379
REMOTE ALARM	Nov-97	2,290
PLUMBING	Nov-97	5,430
REPLACE CONTROLS	Dec-97	3,500
WATER CLOSET	Dec-97	711
DOOR OPERER	Jan-98	3,610
PUMP MOTOR	Jan-98	1,073
WINDOWS	Jan-98	1,158
TOTAL		116,448

BUILDING IMPROVEMENTS		
GUANELLA HALL ROOF	Aug-98	4,500
WATER WELL	Sep-98	6,079
REMOTE GAS & SEWER LINE	Sep-98	8,455
NEW TILE FLOORS	Sep-98	11,150
EXCAVATION & CONCRETE W	Sep-98	13,785
NEW DOORS	Oct-98	7,460
ROOF DE-ICER CABLES	Oct-98	1,867
EXTERIOR PAINT	Nov-98	2,894
METAL DOOR	Dec-98	2,895
REPAIR & REWIRE SCANNER	Jan-99	4,475
REPAIR AIR HANDLING UNIT	Jan-99	2,874
AIR HANDLING CONTROLS	Jan-99	2,299
NEW CHAPEL ROOF	Mar-99	26,040
NEW SHOWER CABINET	Mar-99	5,303
GARAGE DOORS	Mar-99	3,690
INSTALL SHOWER CABINET	Apr-99	2,425
DRAPES	Mar-99	1,097
ENTRY DOOR	Apr-99	5,565
REPAIR ROOF	Jun-99	2,880
REPLACE SHINGLES	Jun-99	4,500
TOTAL		121,823

BUILDING IMPROVEMENTS		
NEW ROOF	Aug-99	1,800
BOILER REPAIRS	Aug-99	2,276
DRAIN TILE	Oct-99	2,500
EXTERIOR PAINT	Sep-99	5,234
NEW PUMPS	Oct-99	2,117
CERAMIC TILE	Nov-99	1,743
HEAT EXCHANGER	Nov-99	3,608
BOILER SWITCH	Nov-99	2,736
CONDENSATE PUMP	Apr-00	4,325
FIRE DOOR	Apr-00	2,785
HOT WATER LINE	Apr-00	2,843
BOILER CONTROLS	Jun-00	5,048
TOTAL		37,015

BUILDING IMPROVEMENTS		
EVAPORATOR COIL IN KITCHE	Jul-00	2,400
BOILER GASKET	Aug-00	2,508
HEAT EXCHANGER	Aug-00	4,697
PLASTER SWIMMING POOL	Nov-00	14,880
REPLACE SERVICE COIL	1-Jan	3,900
PUMP IN ST. ALS.	1-Jan	2,094
SHOWER CABINET	1-Jan	5,550
FURNITURE IN DAY ROOM	1-Jan	9,573
WINDOW BLINDS	1-Mar	3,500
DOUBLE OVEN /KITCHEN	1-Apr	7,950
POOL COMPRESSOR	1-Apr	13,600
WINDOW BLINDS	1-Apr	3,500
ROOF CABLES THERAPY	1-Jun	4,860
TOTAL		76,612

MOUNT ST. JOSEPH OOO5520 7/01/00-6/30/01

XVIL. INCOME STATEMENT OTHER REVENUE PAGE 19

DAY TRAINING PROGRAM FEE LINE28a 393,873

