

			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>0013862</u></p> <p>Facility Name: <u>St Joseph Home of Peoria</u></p> <p>Address: <u>2223 West Heading Avenue</u> <u>West Peoria</u> <u>61604</u> Number City Zip Code</p> <p>County: <u>Peoria</u></p> <p>Telephone Number: <u>(309) 673-7425</u> Fax # <u>(309) 673-7430</u></p> <p>IDPA ID Number: <u>370676431001</u></p> <p>Date of Initial License for Current Owners: <u>unknown</u></p> <p>Type of Ownership:</p> <table border="0"> <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 <u>501C3</u></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>Sister Mary Dries</u> Telephone Number: <u>(309) 673-7430</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 <u>501C3</u>	<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>07/01/00</u> to <u>06/30/01</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"> <tr> <td data-bbox="1129 678 1266 829">Officer or Administrator of Provider</td> <td data-bbox="1266 678 1890 748">(Signed) _____ (Date) <u>09/27/01</u> (Type or Print Name) <u>Sister Mary Dries</u></td> </tr> <tr> <td data-bbox="1129 829 1266 1045">Paid Preparer</td> <td data-bbox="1266 829 1890 1045">(Title) <u>Co-Administrator</u> (Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) (_____) Fax # (____)</td> </tr> </table> <p align="right">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) <u>09/27/01</u> (Type or Print Name) <u>Sister Mary Dries</u>	Paid Preparer	(Title) <u>Co-Administrator</u> (Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) (_____) Fax # (____)
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																											
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Paid Preparer	(Title) <u>Co-Administrator</u> (Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) (_____) Fax # (____)																												

Facility Name & ID Number St Joseph Home of Peoria

0013862 Report Period Beginning: 07/01/00 Ending: 06/30/01

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	43	Intermediate (ICF)	43	15,695	3
4		Intermediate/DD			4
5	146	Sheltered Care (SC)	146	53,290	5
6		ICF/DD 16 or Less			6
7	189	TOTALS	189	68,985	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		Public Aid Recipient	Private Pay	Other		
8	SNF					8
9	SNF/PED					9
10	ICF	6,255	8,317		14,572	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	8,107	32,773		40,880	13
14	TOTALS	14,362	41,090		55,452	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4) 80.38%

D. How many bed-hold days during this year were paid by Public Aid?

25 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

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

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

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

I. On what date did you start providing long term care at this location
Date started November 1958

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: _____ Fiscal Year: 6/30

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

STATE OF ILLINOIS

Facility Name & ID Number St Joseph Home of Peoria # 0013862 Report Period Beginning: 07/01/00 Ending: 06/30/01

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
1	A. General Services										
1	Dietary			792,124	792,124		792,124	(79,955)	712,169		1
2	Food Purchase										2
3	Housekeeping	326,862	34,976	23,038	384,876		384,876	(15,902)	368,974		3
4	Laundry										4
5	Heat and Other Utilities			213,136	213,136		213,136	(13,176)	199,960		5
6	Maintenance	93,272	21,446	40,806	155,524		155,524		155,524		6
7	Other (specify):*										7
8	TOTAL General Services	420,134	56,422	1,069,104	1,545,660		1,545,660	(109,033)	1,436,627		8
	B. Health Care and Programs										
9	Medical Director			300	300		300		300		9
10	Nursing and Medical Records	1,302,918	45,055	330,098	1,678,071		1,678,071	(222,198)	1,455,873		10
10a	Therapy	21,581		1,226	22,807		22,807		22,807		10a
11	Activities	47,752	6,178	15,892	69,822		69,822		69,822		11
12	Social Services	10,379			10,379		10,379		10,379		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,382,630	51,233	347,516	1,781,379		1,781,379	(222,198)	1,559,181		16
	C. General Administration										
17	Administrative			70,124	70,124		70,124		70,124		17
18	Directors Fees										18
19	Professional Services			16,602	16,602		16,602		16,602		19
20	Dues, Fees, Subscriptions & Promotion			7,518	7,518		7,518	(5,660)	1,858		20
21	Clerical & General Office Expense	40,667	11,513	23,228	75,408		75,408		75,408		21
22	Employee Benefits & Payroll Tax			331,255	331,255		331,255	(38,668)	292,587		22
23	Inservice Training & Education			481	481		481		481		23
24	Travel and Seminar			380	380		380		380		24
25	Other Admin. Staff Transportation			2,533	2,533		2,533	(1,317)	1,216		25
26	Insurance-Prop.Liab.Malpractice			26,899	26,899		26,899		26,899		26
27	Other (specify):* Fund Dvlp; IPAC	24,038	22,701	3,700	50,439		50,439	(50,439)			27
28	TOTAL General Administration	64,705	34,214	482,720	581,639		581,639	(96,084)	485,555		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,867,469	141,869	1,899,340	3,908,678		3,908,678	(427,315)	3,481,363		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 St Joseph Home of Peoria

#0013862

Report Period Beginning: 07/01/00

Ending: 06/30/01

06/30/01

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			143,038	143,038		143,038	(6,220)	136,818			30
31	Amortization of Pre-Op. & Org											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicle:											35
36	Other (specify): ³											36
37	TOTAL Ownership			143,038	143,038		143,038	(6,220)	136,818			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportatior											38
39	Ancillary Service Center:											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shop:	14,149	38,024		52,173		52,173		52,173			41
42	Provider Participation Fee			21,608	21,608		21,608		21,608			42
43	Other (specify): ³ Srs. Maintenance			3,428	3,428		3,428	(3,428)				43
44	TOTAL Special Cost Centers	14,149	38,024	25,036	77,209		77,209	(3,428)	73,781			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,881,618	179,893	2,067,414	4,128,925		4,128,925	(436,963)	3,691,962			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 St Joseph Home of Peoria

0013862

Report Period Beginning: 07/01/00

Ending: 06/30/01

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 Program				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Room				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patient				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refund	3,700	27		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	7,572	30		14
15	Non-Care Related Owner's Transaction				15
16	Personal Expenses (Including Transportation)	1,317	25		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainer				22
23	Malpractice Insurance for Individual				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	52,399	20, 27		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employee				27
28	Yellow Page Advertising	2,029	20		28
29	Other-Attach Schedule	373,326	See H		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 440,343		\$	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)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS)			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ 440,343		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 Shop		X			40
41	Barber and Beauty Shops		X			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)			\$		47

St Joseph Home of Peoria

ID# 0013862

Report Period Beginning: 07/01/00

Ending: 06/30/01

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	Total	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number St Joseph Home of Peoria

0013862

Report Period Beginning:

07/01/00

Ending:

06/30/01

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	2,029	0	0	0	0	0	0	0	0	0	0	2,029	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	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	1,317	0	0	0	0	0	0	0	0	0	0	1,317	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	3,700	0	0	0	0	0	0	0	0	0	0	3,700	27
28	TOTAL General Administration	7,046	0	0	0	0	0	0	0	0	0	0	7,046	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	7,046	0	0	0	0	0	0	0	0	0	0	7,046	29

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

* Total must agree with the amount recorded on line 34 of Schedule V1

Facility Name & ID Number St Joseph Home of Peoria # 0013862 Report Period Beginning: 07/01/00 Ending: 06/30/01

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	NONE								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number St Joseph Home of Peoria # 0013862 Report Period Beginning: 07/01/00 Ending: 06/30/01

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

Facility Name & ID Number **St Joseph Home of Peoria** # **0013862** Report Period Beginning: **07/01/00** Ending: **06/30/01**

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2	3	4	5	6		8	9	10									
						Name of Lender	Related**				Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
							YES							NO	Original				Balance
	A. Directly Facility Related																		
	Long-Term																		
1	N/A						\$	\$		\$	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.)

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

B. Real Estate Taxes

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and l must accompany the cost report</p>			
1. Real Estate Tax accrual used on 2000 report.		\$ TAX EXEMP	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).		\$ #VALUE!	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		\$ #VALUE!	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	1996	8	
	1997	9	
	1998	10	
	1999	11	
	2000	12	
	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

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 filec

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 St Joseph Home of Peoria COUNTY Peoria

FACILITY IDPH LICENSE NUMBER 0013862

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 St Joseph Home of Peoria

0013862 Report Period Beginning:

07/01/00 Ending:

06/30/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 120,516 B. General Construction Type: Exterior Brick Frame Cement Block, Steel Number of Stories _____

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 ground (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, et List entity name, type of business, square footage, and number of beds/units available (where applicable)

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

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

Nature of Costs: _____
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1		566,280	1950	\$ 27,936	1
2					2
3	TOTALS	566,280		\$ 27,936	3

Facility Name & ID Number St Joseph Home of Peoria

0013862

Report Period Beginning:

07/01/00

Ending:

06/30/01

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	194	1958	31-Dec-58	\$ 2,132,689	\$ 42,654	50	\$ 42,654	\$	\$ 1,810,137	4
5		1979	31-Dec-79	10,889		20			10,889	5
6		2001	12-Mar-01	4,836	81	20	81		81	6
7										7
8										8
Improvement Type**										
9	Building Improvements		31-Dec-74	11,596		15			11,596	9
10	Building Improvements		31-Dec-75	6,540		15			6,540	10
11	Building Improvements		31-Dec-76	3,731		15			3,731	11
12	Building Improvements		31-Dec-77	1,333		15			1,333	12
13	Blacktopping		31-Dec-78	35,175		15			35,175	13
14	Building Improvements		31-Dec-79	23,573		10			23,573	14
15	Sealer Work		31-Dec-80	4,080		5			4,080	15
16	Convert B Wing		31-Dec-82	23,832		15			23,832	16
17	Showers, Roof		31-Dec-83	10,862		15			10,862	17
18	Bushes		31-Dec-83	1,928		5			1,928	18
19	Roofing, Firewall, Etc.		31-Dec-84	42,124		15			42,124	19
20	Phone System		31-Dec-84	7,600		10			7,600	20
21	Roofing, Plumbing, Tile		31-Dec-85	60,141	2,004	15	2,004		60,141	21
22	Miscellaneous Building Improvement		31-Dec-86	124,144	8,276	15	8,276		120,003	22
23	Miscellaneous Building Improvement		31-Dec-87	152,500	10,167	15	10,167		137,256	23
24	Building Improvements		31-Dec-88	21,760	1,451	15	1,451		18,137	24
25	Parking Lot		31-Dec-88	6,334		5			6,334	25
26	Carpeting		31-Dec-89	1,391		10			1,391	26
27	Lights, Poles, Install		31-Dec-89	4,809	321	15	321		3,531	27
28	Replace Water Heaters		31-Dec-89	36,519	2,445	15	2,435	(10)	26,785	28
29	Miscellaneous Building Improvement		31-Dec-90	24,321	1,621	15	1,621		17,021	29
30	Miscellaneous Building Improvement		31-Dec-90	5,218	259	10	259		5,218	30
31	Bathroom Remodel		31-Dec-91	5,837	389	15	389		3,695	31
32	Bathroom Remodel (2)		31-Oct-92	5,954	397	15	397		3,439	32
33	Bathroom Remodel (1)		30-Sep-92	3,833	256	15	256		2,239	33
34	Install Showers (2)		30-Sep-92	4,556	304	15	304		2,659	34
35	Replace Doors		28-Feb-93	2,195	146	15	146		1,217	35
36										36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number St Joseph Home of Peoria

0013862

Report Period Beginning:

07/01/00

Ending:

06/30/01

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	Beauty Shop Improvements	1-Jun-94	\$ 1,296	\$ 86	15	\$ 86	\$	\$ 609		37
38	Photo Eye & Lamp	1-Jun-94	2,185	146	15	146		1,034		38
39	Asbestos Removal	30-Jun-90	19,985		18	1,110	1,110	12,211		39
40	Sodium Lights	14-Feb-95	3,505	234	15	234		1,501		40
41	Remodel Showers	31-Aug-95	13,703	914	15	914		5,027		41
42	Alarm System	1-Jul-96	3,103	443	7	443		2,215		42
43	Carpet	30-Jan-97	500	71	7	71		314		43
44	Roof	9-Dec-97	90,018	9,002	10	9,002		32,257		44
45	Asbestos Removal & Plumbing	29-Nov-97	18,500	925	20	925		3,315		45
46	Asbestos Removal & Plumbing	17-Apr-98	19,800	990	20	990		3,135		46
47	Lamps	9-Dec-97	16,817	2,402	7	2,402		8,525		47
48	Windows	31-Aug-98	1,903	95	20	95		277		48
49	New Sewer Line to Grease Pit	28-Feb-99	1,730	173	10	173		418		49
50	New Pipes & Repairs	31-Mar-99	839	84	10	84		196		50
51	Tiles & Flooring	20-Apr-99	1,950	195	10	195		439		51
52	Alarm System	30-Apr-99	13,729	915	15	915		2,059		52
53	Pave Parking Lot	25-May-99	64,959	8,120	8	8,120		17,593		53
54	Remove Wall & Put in Door	2-Nov-98	1,050	70	15	70		187		54
55	Remove Wall & Put in Door	24-Mar-99	1,350	90	15	90		210		55
56	Sidewalks	3-Jun-99	4,440	296	15	296		616		56
57	Parker Bath with Electric Adjustment	17-Jan-00	8,900	890	10	890		1,335		57
58	Lathe & Plaster Repairs	29-Jan-00	1,536	154	10	154		231		58
59	Bath Remodel	5-Jan-00	877	88	10	88		132		59
60	Light Fixtures	17-Mar-00	413	41	10	41		55		60
61	Tile Repair in Washtub Area	4-Apr-00	1,369	137	10	137		171		61
62	Carpet	19-Jun-00	659	66	10	66		71		62
63	Carpet	31-Jan-00	525	52	10	52		78		63
64	4'x8' Two-sided Sign & Posts	17-Jan-00	1,800	180	10	180		270		64
65	Sidewalks	1-Jun-00	2,200	147	15	147		159		65
66	Asbestos Removal	15-Sep-00	12,500	521	20	521		521		66
67	Fixtures	31-Oct-00	9,291	619	10	619		619		67
68	Carpet	31-May-01	705	6	10	6		6		68
69	Wrought Iron Fence and Gate	8-Aug-00	1,175	72	15	72		72		69
70	TOTAL (lines 4 thru 69)		\$ 3,103,612	\$ 98,995		\$ 100,095	\$ 1,100	\$ 2,498,405		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 instruction

	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	\$ 245,794	\$ 30,176	\$ 30,176	\$	5 to 10	\$ 222,355	71
72	Current Year Purchases	31,243	1,969	1,969		5 to 10	1,969	72
73	Fully Depreciated Assets	476,724					476,724	73
74								74
75	TOTALS	\$ 753,761	\$ 32,145	\$ 32,145	\$		\$ 701,048	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	Long-Term Care	Chevy Truck-1985	31-Dec-91	\$ 9,042	\$	\$			\$ 9,042	76
77	Long-Term Care	Chevy Lumina-1993	17-Aug-95	15,202	1,522	1,522			15,202	77
78	Long-Term Care	Ford Escort-1997	18-Jul-96	15,279	3,056	3,056			15,025	78
79										79
80	TOTALS			\$ 39,523	\$ 4,578	\$ 4,578	\$		\$ 39,269	80

E. Summary of Care-Related Asset

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 3,924,832	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 135,718	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 136,818	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 1,100	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,238,722	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	Retired Sisters Convent	\$ 288,400	\$ 7,210	\$ 212,695	86
87	Working Sisters Housed in Home				87
88	Portion of Depreciation		5,040		88
89	Carpeting in Retired Sisters Convent	2,964	371	1,020	89
90					90
91	TOTALS	\$ 291,364	\$ 12,621	\$ 213,715	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 1

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 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	N/A			\$			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. _____ /2002 \$ _____
 13. _____ /2003 \$ _____
 14. _____ /2004 \$ _____

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

* 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.

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? <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>We hire only certified aides</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 AIDE _____</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 AIDE _____</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)				
4 Clinical Wages (b)				
5 In-House Trainer Wage (c)				
6 Transportation				
7 Contractual Payment:				
8 Nurse Aide Competency Tests				
9 TOTALS	\$	\$	\$	\$
10 SUM OF line 9, col. 1 and 2 (e)	\$			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefit;
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefit;
- (c) For in-house training programs only. Do not include fringe benefit;
- (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	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (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	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	N/A	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		visits							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			\$		\$	\$		\$	14

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

Facility Name & ID Number St Joseph Home of Peoria # 0013862 Report Period Beginning: 07/01/00 Ending: 06/30/01
 XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/01 (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	\$ 168,036	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	142,062		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	31,311		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Deferred Expense</u>	2,758		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 344,167	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments	1,801,308		12
13	Land	153,532		13
14	Buildings, at Historical Cost	3,244,338		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	823,026		16
17	Accumulated Depreciation (book methods)	(3,369,769)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	556,321		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Deferred Expenses L/T</u>	9,659		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,218,415	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,562,582	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 222,817	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	74,234		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
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 297,051	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 297,051	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,265,531	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,562,582	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,321,736	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,321,736	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(56,205)	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 Owner:	()	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)	\$ (56,205)	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)	\$ 3,265,531	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number St Joseph Home of Peoria

0013862

Report Period Beginning: 07/01/00

Ending: 06/30/01

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 expenses.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,153,481	1
2	Discounts and Allowances for all Level	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,153,481	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Educator		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursement		11
12	Gift and Coffee Shop	37,877	12
13	Barber and Beauty Care	3,366	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patient		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)	\$ 41,243	23
D. Non-Operating Revenue			
24	Contributions	354,703	24
25	Interest and Other Investment Income**	150,191	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 504,894	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Sisters Maintenance & Chapel	372,256	28
28a	Miscellaneous	846	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 373,102	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,072,720	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,545,660	31
32	Health Care	1,781,379	32
33	General Administrator	581,639	33
B. Capital Expense			
34	Ownership	143,038	34
C. Ancillary Expense			
35	Special Cost Centers	55,601	35
36	Provider Participation Fee	21,608	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,128,925	40
41	Income before Income Taxes (line 30 minus line 40)**	(56,205)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (56,205)	43

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

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

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

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

Facility Name & ID Number **St Joseph Home of Peoria**

0013862

Report Period Beginning: **07/01/00**

Ending:

06/30/01

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	2,014	2,062	\$ 39,169	\$ 19.00	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,381	8,218	123,556	15.03	3
4	Licensed Practical Nurses	27,832	31,332	431,109	13.76	4
5	Nurse Aides & Orderlies	48,941	52,971	486,886	9.19	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,824	2,088	21,581	10.34	8
9	Activity Director	1,939	2,183	20,320	9.31	9
10	Activity Assistants	3,856	3,905	27,432	7.02	10
11	Social Service Worker	977	1,002	10,379	10.36	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Worker	6,897	7,477	93,272	12.47	17
18	Housekeepers	34,411	38,245	310,960	8.13	18
19	Laundry					19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative	1,805	1,989	24,038	12.09	22
23	Office Manager					23
24	Clerical	4,161	4,387	40,667	9.27	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) <u>Snack Bar Worker</u>	1,490	1,740	14,149	8.13	33
34	TOTAL (lines 1 - 33)	143,528	157,599	\$ 1,643,518 *	\$ 10.43	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant			35	
36	Medical Director	3	300	L 9, Col 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	29	1,226	L 10a, Col 3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	19	695	L 11, Col 3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	51	\$ 2,221		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	534	\$ 18,453	L 10, Col 3	50
51	Licensed Practical Nurses	2,036	59,799	L 10, Col 3	51
52	Nurse Aides	7,866	122,240	L 10, Col 3	52
53	TOTAL (lines 50 - 52)	10,436	\$ 200,492		53

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	5 Amount of Expense Amortized Per Year								
					6 FY1998	7 FY1999	8 FY2000	9 FY2001	10 FY2002	11 FY2003	12 FY2004	13 FY2005	14 FY2006
1	Repair Temp Control	04-Sep-98	\$ 784	5	\$	\$ 131	\$ 157	\$ 157	\$	\$	\$	\$	\$
2	Tree Removal & Trim	22-Sep-98	1,750	3		486	583	583					
3	Repair Roof	30-Nov-98	2,162	3		481	721	721					
4	Repair Roof	31-Mar-99	3,230	3		359	1,077	1,077					
5	Plaster Repair	03-Apr-99	9,698	10		242	970	970					
6	Repair Heat Exchange	28-Apr-99	651	3		54	217	217					
7	Plumbing Repairs	31-Aug-99	4,137	10			379	414					
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 22,412		\$	\$ 1,753	\$ 4,104	\$ 4,139	\$	\$	\$	\$	\$

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 Illinois Nursing Home Administrators Assoc.
- (3) Did the nursing home make political contributions or payments to a political 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? Yes If YES, what is the capacity? 187
- (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? _____
- (6) Indicate the total amount of both disposable and non-disposable diaper expenses and the location of this expense on Sch. V. 13,865 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation _____
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease _____
- (9) Are you presently operating under a sublease agreement? YES _____ NO X
- (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. 21,608
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 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? N/A
- (14) Is a portion of the building used for any function other than long term care services if 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? N/A 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? No If YES, please indicate the amount of income earned from such program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 7%
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ 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? N/A
Attach invoices and a summary of services for all architect and appraisal fees _____