



Facility Name & ID Number ST. JOSEPH'S HOME OF PEORIA

# 0013862 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

**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 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	7,777	7,402		15,179	10
11	ICF/DD					11
12	SC	9,306	25,708		35,014	12
13	DD 16 OR LESS					13
14	TOTALS	17,083	33,110		50,193	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 72.76%

D. How many bed-hold days during this year were paid by Public Aid? 0 (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 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 N/A

**IV. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: EXEMPT Fiscal Year: 6/30

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

## STATE OF ILLINOIS

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Facility Name & ID Number **ST. JOSEPH'S HOME OF PEORIA** # **0013862** Report Period Beginning: **07/01/2003** Ending: **06/30/2004****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
	<b>A. General Services</b>										
1	Dietary			804,300	804,300		804,300	(54,763)	749,537		1
2	Food Purchase										2
3	Housekeeping	329,302	29,805	13,160	372,267		372,267	(28,228)	344,039		3
4	Laundry										4
5	Heat and Other Utilities			215,480	215,480		215,480	(12,853)	202,627		5
6	Maintenance	98,127	20,574	46,262	164,963		164,963		164,963		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	427,429	50,379	1,079,202	1,557,010		1,557,010	(95,844)	1,461,166		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			400	400		400		400		9
10	Nursing and Medical Records	1,506,850	50,332	286,130	1,843,312		1,843,312	(211,041)	1,632,271		10
10a	Therapy	24,060		2,186	26,246		26,246		26,246		10a
11	Activities	61,897	14,894	2,489	79,280		79,280		79,280		11
12	Social Services	8,357			8,357		8,357		8,357		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,601,164	65,226	291,205	1,957,595		1,957,595	(211,041)	1,746,554		16
	<b>C. General Administration</b>										
17	Administrative			57,354	57,354		57,354		57,354		17
18	Directors Fees										18
19	Professional Services			66,611	66,611		66,611	(13,730)	52,881		19
20	Dues, Fees, Subscriptions & Promotions			11,713	11,713		11,713	(7,154)	4,559		20
21	Clerical & General Office Expenses	59,097	12,244	54,201	125,542		125,542	(1,235)	124,307		21
22	Employee Benefits & Payroll Taxes			427,676	427,676		427,676	(47,848)	379,828		22
23	Inservice Training & Education										23
24	Travel and Seminar			555	555		555		555		24
25	Other Admin. Staff Transportation			3,714	3,714		3,714	(961)	2,753		25
26	Insurance-Prop.Liab.Malpractice			35,162	35,162		35,162		35,162		26
27	Other (specify):*	26,025	16,778	37,435	80,238		80,238	(44,712)	35,526		27
28	<b>TOTAL General Administration</b>	85,122	29,022	694,421	808,565		808,565	(115,640)	692,925		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,113,715	144,627	2,064,828	4,323,170		4,323,170	(422,525)	3,900,645		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number

ST. JOSEPH'S HOME OF PEORIA

#0013862

Report Period Beginning:

07/01/2003

Ending:

06/30/2004

## 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	
	<b>D. Ownership</b>											
30	Depreciation			131,989	131,989		131,989	(6,481)	125,508			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			1,423	1,423		1,423		1,423			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			133,412	133,412		133,412	(6,481)	126,931			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops	4,566	44,126		48,692		48,692		48,692			41
42	Provider Participation Fee			23,478	23,478		23,478		23,478			42
43	Other (specify):*			2,749	2,749		2,749	(2,749)				43
44	<b>TOTAL Special Cost Centers</b>	4,566	44,126	26,227	74,919		74,919	(2,749)	72,170			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,118,281	188,753	2,224,467	4,531,501		4,531,501	(431,755)	4,099,746			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **ST. JOSEPH'S HOME OF PEORIA**

# **0013862**

Report Period Beginning: **07/01/2003**

Ending: **06/30/2004**

**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				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	1,100	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	(1,909)	27		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(961)	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 Retainers	(13,730)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(42,803)	27		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(5,624)	20		28
29	Other-Attach Schedule SEE PAGE 5A	(367,828)	VAR		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (431,755)		\$	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	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
37	<b>TOTAL ADJUSTMENTS (A) and (B) (sum of SUBTOTALS)</b>	\$ (431,755)		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			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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

ST. JOSEPH'S HOME OF PEORIA

ID# 0013862

Report Period Beginning: 07/01/2003

Ending: 06/30/2004

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	EXPENSES OF INFIRMED AND RETIRED	\$		1
2	SISTERS LIVING IN CONVENT			2
3	UTILITIES	(12,853)	5	3
4	NURSING SALARIES	(211,041)	10	4
5	EMPLOYEE BENEFITS AND TAXES	(47,848)	22	5
6	HOUSEKEEPING	(28,228)	3	6
7	DEPRECIATION	(7,581)	30	7
8	FOOD	(54,763)	1	8
9	OTHER EXPENES	(2,749)	43	9
10				10
11	ST JOSEPH'S HOME HAS BEEN REIMBURSED FOR THE SISTER'S EXPENSES			11
12	BY THE MOTHER HOUSE			12
13				13
14				14
15	GIFTS	(1,235)	21	15
16	NON ALLOWABLE ADVERTISING	(1,530)	20	16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(367,828)		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number ST. JOSEPH'S HOME OF PEORIA

# 0013862 Report Period Beginning:

07/01/2003

Ending:

06/30/2004

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)	
	<b>A. General Services</b>													
1	Dietary	(54,763)	0	0	0	0	0	0	0	0	0	0	(54,763)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	(28,228)	0	0	0	0	0	0	0	0	0	0	(28,228)	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(12,853)	0	0	0	0	0	0	0	0	0	0	(12,853)	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	<b>TOTAL General Services</b>	<b>(95,844)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(95,844)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(211,041)	0	0	0	0	0	0	0	0	0	0	(211,041)	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	<b>TOTAL Health Care and Programs</b>	<b>(211,041)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(211,041)</b>	<b>16</b>
	<b>C. General Administration</b>													
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	(13,730)	0	0	0	0	0	0	0	0	0	0	(13,730)	19
20	Fees, Subscriptions & Promotions	(7,154)	0	0	0	0	0	0	0	0	0	0	(7,154)	20
21	Clerical & General Office Expenses	(1,235)	0	0	0	0	0	0	0	0	0	0	(1,235)	21
22	Employee Benefits & Payroll Taxes	(47,848)	0	0	0	0	0	0	0	0	0	0	(47,848)	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	(961)	0	0	0	0	0	0	0	0	0	0	(961)	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(44,712)	0	0	0	0	0	0	0	0	0	0	(44,712)	27
28	<b>TOTAL General Administration</b>	<b>(115,640)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(115,640)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(422,525)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(422,525)</b>	<b>29</b>

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number ST. JOSEPH'S HOME OF PEORIA# 0013862

Report Period Beginning:

07/01/2003

Ending:

06/30/2004

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)
	<b>D. Ownership</b>												
30	Depreciation	(6,481)	0	0	0	0	0	0	0	0	0	0	(6,481) 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0 32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0 33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0 34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0 35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 36
37	<b>TOTAL Ownership</b>	<b>(6,481)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(6,481) 37</b>
	<b>Ancillary Expense</b>												
	<b>E. Special Cost Centers</b>												
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0 38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0 39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0 40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0 41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0 42
43	Other (specify):*	(2,749)	0	0	0	0	0	0	0	0	0	0	(2,749) 43
44	<b>TOTAL Special Cost Centers</b>	<b>(2,749)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(2,749) 44</b>
	<b>GRAND TOTAL COST</b>												
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(431,755)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(431,755) 45</b>

**VII. RELATED PARTIES**

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE PAGE 6A, SCHEDULE OF BOARD OF DIRECTORS						

**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	N/A	\$			\$	\$	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 VI.

SEE ACCOUNTANTS' COMPILATION REPORT

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	N/A								\$	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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ST. JOSEPH'S HOME OF PEORIA # 0013862 Report Period Beginning: 07/01/2003 Ending: 6/30/2004

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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	N/A				\$	\$		\$	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

SEE ACCOUNTANTS' COMPILATION REPORT

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

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ \_\_\_\_\_ Line # \_\_\_\_\_

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
 (See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number **ST. JOSEPH'S HOME OF PEORIA**# **0013862** Report Period Beginning: **07/01/2003** Ending: **06/30/2004****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

		<b>Important</b> , 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 2003 report.	\$	<b>TAX EXEMPT</b>		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).	\$	<b>#VALUE!</b>		3
4.	Real Estate Tax accrual used for 2004 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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>	\$			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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>	\$			6
7.	Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	<b>#VALUE!</b>		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		1999	_____	8	
		2000	_____	9	
		2001	_____	10	
		2002	_____	11	
		2003	_____	12	
<b>FOR OHF USE ONLY</b>					
13	FROM R. E. TAX STATEMENT FOR 2003	\$			13
14	PLUS APPEAL COST FROM LINE 5	\$			14
15	LESS REFUND FROM LINE 6	\$			15
16	AMOUNT TO USE FOR RATE CALCULATION	\$			16

**NOTES:**

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

SEE ACCOUNTANTS' COMPILATION REPORT

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 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 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 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 2004 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.

**2003 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME ST. JOSEPH'S 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 2003 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 2003.

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

**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 original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number ST. JOSEPH'S HOME OF PEORIA# 0013862 Report Period Beginning:07/01/2003 Ending:06/30/2004**X. BUILDING AND GENERAL INFORMATION:**A. Square Feet: 120,516 B. General Construction Type: Exterior BRICK Frame CEMENT BLOCK 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).

NONEF. 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>566,280</u>	<u>1950</u>	<u>\$ 27,936</u>	1
2					2
3	<b>TOTALS</b>	<b>566,280</b>		<b>\$ 27,936</b>	<b>3</b>

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number ST. JOSEPH'S HOME OF PEORIA

# 0013862

Report Period Beginning:

07/01/2003 Ending: 06/30/2004

**XL 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	12/31/1958	\$ 2,132,689	\$ 42,654	50	\$ 42,654	\$	\$ 1,938,099
5		1979	12/31/1979	10,889		50			10,889
6		2001	3/21/2001	4,836	242	20	242		807
7		2003	10/16/2003	2,985	112	20	112		112
8									
	<b>Improvement Type**</b>								
9	BLDG IMPROVEMENTS		12/31/1974	11,596		15			11,596
10	BLDG IMPROVEMENTS		12/31/1975	6,540		15			6,540
11	BLDG IMPROVEMENTS		12/31/1976	3,731		15			3,731
12	BLDG IMPROVEMENTS		12/31/1977	1,333		15			1,333
13	BLACKTOPPING		12/31/1978	35,175		15			35,175
14	BLDG IMPROVEMENTS		12/31/1979	23,573		10			23,573
15	SEALER WORK		12/31/1980	4,080		5			4,080
16	CONVERT B WING		12/31/1982	23,832		15			23,832
17	SHOWERS, ROOF		12/31/1983	10,862		15			10,862
18	BUSHES		12/31/1983	1,928		5			1,928
19	ROOFING, FIREWALL, ETC		12/31/1984	42,124		15			42,124
20	PHONE SYSTEM		12/31/1984	7,600		10			7,600
21	ROOFING, PLUMBING, TILE		12/31/1985	60,141		15			60,141
22	BLDG IMPROVEMENTS		12/31/1986	124,144		15			124,144
23	BLDG IMPROVEMENTS		12/31/1987	152,500	862	15	862		152,500
24	BLDG IMPROVEMENTS		12/31/1988	21,760	721	15	721		21,760
25	PARKING LOT		12/31/1988	6,334		5			6,334
26	CARPETING		12/31/1989	1,391		10			1,391
27	LIGHTS, POLES, INSTALL		12/31/1989	4,809	321	15	321		4,494
28	REPLACE WATER HEATERS		12/31/1989	36,519	2,445	15	2,435	(10)	34,090
29	BLDG IMPROVEMENTS		12/31/1990	24,321	1,621	15	1,621		21,884
30	BLDG IMPROVEMENTS		12/31/1990	5,218		10			5,218
31	BATHROOM REMODEL		12/31/1991	5,837	389	15	389		4,862
32	BATHROOM REMODEL		10/31/1992	5,954	397	15	397		4,630
33	BATHROOM REMODEL		9/30/1992	3,833	256	15	256		3,007
34	INSTALL 2 SHOWERS		9/30/1992	4,556	304	15	304		3,571
35	REPLACE DOORS		2/28/2003	2,195	146	15	146		1,655
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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number ST. JOSEPH'S HOME OF PEORIA

# 0013862

Report Period Beginning:

07/01/2003 Ending: 06/30/2004

## 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	6/1/1994	\$ 1,296	\$ 86	15	\$ 86	\$	\$ 867		37
38	PHOTO EYE AND LAMP	6/1/1994	2,185	146	15	146		1,472		38
39	ASBESTOS REMOVAL	6/30/1990	19,985		18	1,110	1,110	15,541		39
40	SODIUM LIGHTS	2/14/1995	3,505	234	15	234		2,203		40
41	REMODEL SHOWERS	8/31/1995	13,703	914	15	914		7,769		41
42	ALARM SYSTEM	7/1/1996	3,103	2	7	2		3,103		42
43	CARPET	1/30/1997	500	44	7	44		500		43
44	ROOF	12/9/1997	90,018	9,002	10	9,002		59,263		44
45	ASBESTOS REMOVAL AND PLUMBING	11/29/1997	18,500	925	20	925		6,090		45
46	ASBESTOS REMOVAL AND PLUMBING	4/17/1998	19,800	990	20	990		6,105		46
47	LAMPS	12/9/1997	16,817	2,402	7	2,402		15,731		47
48	WINDOWS	8/31/1998	1,903	95	20	95		562		48
49	NEW SEWER LINE TO GREASE PIT	2/28/1999	1,730	173	10	173		937		49
50	NEW PIPESAND REPAIRS	3/31/1999	839	84	10	84		448		50
51	TILES AND FLOORING	4/20/1999	1,950	195	10	195		1,024		51
52	ALARM SYSTEM	4/30/1999	13,729	915	15	915		4,804		52
53	PAVE PARKING LOT	5/25/1999	64,959	8,120	8	8,120		41,953		53
54	REMOVE WALL AND PUT IN DOOR	11/2/1998	1,050	70	15	70		397		54
55	REMOVE WALL AND PUT IN DOOR	3/24/1999	1,350	90	15	90		480		55
56	SIDEWALKS	6/3/1999	4,440	296	15	296		1,504		56
57	PARKER BATH WITH ELECTRIC ADJUSTMENTS	1/17/2000	8,900	890	10	890		4,005		57
58	LATH AND PLASTER REPAIRS	1/29/2000	1,536	154	10	154		693		58
59	BATH REMODEL	1/5/2000	877	88	10	88		396		59
60	LIGHT FIXTURES	3/17/2000	413	41	10	41		178		60
61	TILE REPAIR IN WASHTUB AREA	4/4/2000	1,369	137	10	137		582		61
62	CARPET	6/19/2000	659	66	10	66		269		62
63	CARPET	1/31/2000	525	52	10	52		234		63
64	4X8 TWO-SIDED SIGN AND POST	1/17/2000	1,800	180	15	180		810		64
65	SIDEWALKS	6/1/2000	2,200	147	20	147		600		65
66	ASBESTOS REMOVAL	9/15/2000	12,500	625	10	625		2,396		66
67	FIXTURES	10/31/2000	9,291	929	10	929		3,406		67
68	CARPET	5/31/2001	705	70	15	70		216		68
69	WROUGHT IRON FENCE AND GATES	8/8/2000	1,175	78		78		306		69
70	TOTAL (lines 4 thru 69)		\$ 3,106,597	\$ 78,710		\$ 79,810	\$ 1,100	\$ 2,756,806		70

SEE ACCOUNTANTS' COMPILATION REPORT

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

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	<b>Totals from Page 12A, Carried Forward</b>	\$ 3,106,597	\$ 78,710		\$ 79,810	\$ 1,100	\$ 2,756,806		1
2	FIRE ALARM SYSTEM	10/21/2001 11,850	790	15	790		2,173		2
3	FIRE ALARM SYSTEM	11/20/2001 5,388	359	15	359		928		3
4	LIGHT FIXTURES	2/1/2002 1,171	117	10	117		283		4
5	VENTILATORS	7/3/2001 7,987	532	15	532		1,596		5
6	CARPET	11/21/2001 1,200	120	10	120		310		6
7	CARPET	9/13/2001 707	71	10	71		201		7
8	CARPET	12/12/2001 800	80	10	80		207		8
9	PLASTER WORK	1/11/2002 166	17	10	17		42		9
10	PLASTER WORK	11/23/2001 877	88	10	88		227		10
11	CERAMIC TILE WORK	4/25/2002 1,000	100	10	100		217		11
12	SEWER AND PIPE REPAIR	4/30/2002 20,698	2,070	10	2,070		4,485		12
13	C WING ROOF REPAIR	3/14/2002 3,277	218	15	218		509		13
14	LINOLEUM FLOOR	4/10/2002 1,080	108	10	108		243		14
15	CARPET	4/24/2002 732	73	10	73		158		15
16	ROOF REPAIR	4/30/2002 2,388	159	15	159		345		16
17	BATHROOM AND PLASTERING	5/3/2002 531	53	10	53		115		17
18	ROOF REPAIR	11/30/1998 2,162		3			2,162		18
19	ROOF REPAIR	3/31/1999 3,230		3			3,230		19
20	PLASTER WORK	4/3/1999 9,698	970	10	970		5,091		20
21	ROOF REPAIR	11/23/2002 2,935	196	15	196		359		21
22	TILE WORK	2/20/2003 925	93	10	93		124		22
23	9 WINDOWS AND INSTALLATION	6/11/2003 2,860	286	10	286		310		23
24	INSTALL SMOKE ALARMS	5/21/2003 2,100	140	15	140		152		24
25	TILE FLOORING	12/31/2003 1,099	55	10	55		55		25
26	PUMP REPAIRS	5/13/2004 1,019	17	10	17		17		26
27	ROOF REPAIRS	6/4/2004 2,562	14	15	14		14		27
28	INSTALL FIREPROOF WALL	6/5/2004 1,550	19	15	19		19		28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>	\$ 3,196,589	\$ 85,455		\$ 86,555	\$ 1,100	\$ 2,780,378		34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*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	\$ 267,884	\$ 34,311	\$ 34,311	\$		\$ 172,512	71
72	Current Year Purchases	23,754	1,586	1,586			1,586	72
73	Fully Depreciated Assets	557,984					557,984	73
74								74
75	TOTALS	\$ 849,622	\$ 35,897	\$ 35,897	\$		\$ 732,082	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	1993 CHEVY LUMINA	1995	\$ 15,202	\$	\$	\$		\$ 15,202	76
77	LONG-TERM CARE	1997 FORD ESCORT	1996	15,279					15,279	77
78	LONG-TERM CARE	2002 CHEVY TRUCK	2002	22,104	4,421	4,421			8,105	78
79										79
80	TOTALS			\$ 52,585	\$ 4,421	\$ 4,421	\$		\$ 38,586	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)	\$ 4,126,732	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 125,773	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 126,873	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)	\$ 3,551,046	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	\$ 234,325	86
87	WORKING SISTERS HOUSED				87
88	IN HOME DEPRECIATION		5,040		88
89	CARPET IN RETIRED SISTER CONVE	2,964	371	2,133	89
90					90
91	TOTALS	\$ 291,364	\$ 12,621	\$ 236,458	91

G. Construction-in-Progress

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

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

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

**XII. RENTAL COSTS**

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

1. Name of Party Holding Lease: \_\_\_\_\_  
 2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?  
 If NO, see instructions.  YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions	N/A						4
5								5
6								6
7	<b>TOTAL</b>				\$			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>/2005</u>	\$ _____
13.	<u>/2006</u>	\$ _____
14.	<u>/2007</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: \$ 1,423 Description: RENTAL OF OXYGEN CYLINDERS

(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	N/A		\$	\$	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$	\$	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><b>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</b></p> <p><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><b>2. CLASSROOM PORTION:</b></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><b>3. CLINICAL PORTION:</b></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 Drop-outs	2 Completed	3 Contract	4 Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	<b>TOTALS</b>	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

- (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	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	

- (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.
- SEE ACCOUNTANTS' COMPILATION REPORT**

**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 Total Cost (Col. 3 + 5 + 6)	
			Staff		Outside Practitioner (other than consultant)		Units	Cost	Units	Cost				
			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	<b>TOTAL</b>			\$		\$		\$					\$	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **ST. JOSEPH'S HOME OF PEORIA**

STATE OF ILLINOIS

# **0013862**

Report Period Beginning: **07/01/2003**

Ending:

**06/30/2004**

**XV. BALANCE SHEET - Unrestricted Operating Fund.**

As of **06/30/2004**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 109,456	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	88,259		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	35,894		6
7	Other Prepaid Expenses	570		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 234,179	\$	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments	599,180		12
13	Land	153,532		13
14	Buildings, at Historical Cost	3,337,315		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	931,950		16
17	Accumulated Depreciation (book methods)	(3,771,265)		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): <b>DEFERRED EXPENSE - LT</b>	1,532		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,252,244	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,486,423	\$	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 133,522	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	93,600		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
<b>Other Current Liabilities(specify):</b>				
36				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 227,122	\$	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 227,122	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 1,259,301	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,486,423	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>1,787,700</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>1,787,700</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(528,399)	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(528,399)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>1,259,301</b>	<b>24</b> *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number ST. JOSEPH'S HOME OF PEORIA

# 0013862

Report Period Beginning: 07/01/2003

Ending: 06/30/2004

**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.**

**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 3,297,805	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 3,297,805	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	54,905	12
13	Barber and Beauty Care	3,402	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio	578	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 58,885	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	159,472	24
25	Interest and Other Investment Income***	124,393	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 283,865	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>REIMBURSEMENT OF EXPENSES RELATED TO</b>		28
28a	<b>INFIRMED, RETIRED SISTERS LIVING IN CONVENT</b>	362,547	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 362,547	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 4,003,102	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,557,010	31
32	Health Care	1,957,595	32
33	General Administration	808,565	33
<b>B. Capital Expense</b>			
34	Ownership	133,412	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	51,441	35
36	Provider Participation Fee	23,478	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 4,531,501	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(528,399)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (528,399)	43

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? AX EXEMP 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. SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number **ST. JOSEPH'S HOME OF PEORIA**

# **0013862**

Report Period Beginning: **07/01/2003**

Ending:

**06/30/2004**

**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	2,298	2,467	\$ 51,296	\$ 20.79	1
2	Assistant Director of Nursing	1,079	1,297	22,152	17.08	2
3	Registered Nurses	4,833	5,386	92,298	17.14	3
4	Licensed Practical Nurses	29,279	35,453	527,086	14.87	4
5	Nurse Aides & Orderlies	54,990	62,459	602,977	9.65	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,796	2,101	24,060	11.45	8
9	Activity Director	2,509	2,623	30,321	11.56	9
10	Activity Assistants	4,079	4,264	31,576	7.41	10
11	Social Service Workers	727	727	8,357	11.50	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	6,593	7,450	98,127	13.17	17
18	Housekeepers	22,334	25,260	217,586	8.61	18
19	Laundry	7,679	8,427	83,489	9.91	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative	1,921	2,042	26,025	12.74	22
23	Office Manager					23
24	Clerical	4,829	5,229	59,097	11.30	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</u>	388	492	4,565	9.28	33
34	TOTAL (lines 1 - 33)	145,334	165,677	\$ 1,879,012 *	\$ 11.34	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	4	400	L9C3 36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	56	2,783	L12C3 39
40	Physical Therapy Consultant	47	2,186	L10AC3 40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant	70	2,489	L11C3 43
44	Activity Consultant			44
45	Social Service Consultant			45
46	Other(specify) <u>LEGAL HR</u>	28	2,240	L27C3 46
47				47
48				48
49	TOTAL (lines 35 - 48)	205	\$ 10,098	49

**C. CONTRACT NURSES**

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	160	\$ 4,738	L10C3 50
51	Licensed Practical Nurses	3,651	101,209	L10C3 51
52	Nurse Aides	2,061	34,490	L10C3 52
53	TOTAL (lines 50 - 52)	5,872	\$ 140,437	53

SEE ACCOUNTANTS' COMPILATION REPORT

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
			\$	Workers' Compensation Insurance	\$ 71,545	IDPH License Fee	\$		
				Unemployment Compensation Insurance		Advertising: Employee Recruitment	1,530		
				FICA Taxes	140,388	Health Care Worker Background Check (Indicate # of checks performed)	496		
				Employee Health Insurance	137,086	<b>YELLOW PAGES ADVERTISING</b>	5,624		
				Employee Meals		<b>STATE LICENSES</b>	3,056		
				Illinois Municipal Retirement Fund (IMRF)*		<b>PEORIA COUNTY/CITY PUBLIC HEALTH</b>	150		
				<b>PROFESSIONAL LIAB INS</b>	30,809	<b>INHAA, HIPPA, EMP ASSOC</b>	555		
						<b>SUBSCRIPTIONS</b>	302		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$			Less: Public Relations Expense	( )		
B. Administrative - Other						Non-allowable advertising	(1,530)		
Description			Amount			Yellow page advertising	(5,624)		
<b>SISTER MARY DRIES, CO-ADMINISTRATOR</b>			\$ 7,798						
<b>SISTER MARY PAUL MAZZORANA, CO-ADMINISTRATOR</b>			7,798						
<b>SISTER MARY BARBARA BUKCLEY, ADMINISTRATOR</b>			41,758						
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 57,354	TOTAL (agree to Schedule V, line 22, col.8)	\$ 379,828	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 4,559		
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount	
<b>GINOLI &amp; COMPANY</b>	<b>ACCOUNTING</b>		\$ 14,063			\$	Out-of-State Travel	\$	
<b>INDUSTRIAL DATA &amp; DESIGN</b>	<b>COMPUTER SUPPORT</b>		3,304						
<b>MANAGEMENT PERFORMANCE</b>	<b>OPERATIONS SURVEY</b>		27,932				In-State Travel		
<b>CLIFTON GUNDERSON</b>	<b>COMPUTER SUPPORT</b>		900						
<b>HONKAMP KRUEGER</b>	<b>PAYROLL</b>		5,087						
<b>CB RETIREMENT</b>	<b>ACCOUNT MANAGEMENT</b>		711				Seminar Expense	555	
<b>DAVIS &amp; CAMPBELL</b>	<b>LEGAL</b>		14,614						
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 66,611	TOTAL		\$	Entertainment Expense	( )	
							TOTAL (agree to Sch. V, line 24, col. 8)		\$ 555

\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' COMPILATION REPORT

\*\*See instructions.

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

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	REPAIR TEMP CNTRL	09/04/98	\$ 784	5	\$ 157	\$ 157	\$ 157	\$ 25	\$	\$	\$	\$
2	REPAIR HEAT EXCHAN	04/28/99	651	3	217	163						
3	PLUMBING REPAIRS	08/31/99	4,137	10	414	414	414	414				
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS		\$ 5,572		\$ 788	\$ 734	\$ 571	\$ 439	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number ST. JOSEPH'S HOME OF PEORIA

# 0013862

Report Period Beginning: 07/01/2003

Ending: 06/30/2004

## 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. INHAA \$75
- (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? 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? 12
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 19,276 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 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. \$ 23,478  
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? N/A
- (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? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_
- c. What percent of all travel expense relates to transportation of nurses and patients? 5.6%
- 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? YES  
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS  
ST. JOSEPH'S HOME OF PEORIA

0013862 Report Period Beginning:

Page 24

Facility Name & ID Number

07/01/2003 Ending: 06/30/2004

SCHEDULE V

PAGE 3, LINE 27 - GENERAL ADMINISTRATION

SALARY/WAGE	
FUND DIRECTOR	\$ 26,025
SUPPLIES	
DEVELOPMENT EXPENSE	16,778
OTHER	
IPAC REFUNDS	1,909
CONSULTANT	2,240
BAD DEBTS	33,286
TOTAL PAGE 3, LINE 27, COL 3	<u>\$ 80,238</u>

PAGE 4, LINE 43 - SPECIAL COST CENTERS

SALARY/WAGE	\$ -
SUPPLIES	-
OTHER	
EXPENSES OF SISTERS ON STAFF	
DUES, MEMBERSHIPS, AND SUBSCRIPTION	5
MEDICAL AND DENTAL	44
HOUSE SUPPLIES	1,650
GIFTS	-
EXPENSES OF RETIRED SISTERS LIVING IN BUILDING	
MEDICAL AND DENTAL	99
HOUSE SUPPLIES	951
TOTAL PAGE 4, LINE 43, COL 3	<u>\$ 2,749</u>

SCHEDULE XVIII

PAGE 20, LINE 34

TOTAL DOES NOT AGREE WITH SCHEDULE V, PAGE 3, LINE 45, COL 1 BECAUSE THE TOTAL ON PAGE 4 INCLUDES \$239,269 FOR WAGES OF PERSONNEL WHO WORK WITH THE INFIRMED AND RETIRED SISTERS. THIS AMOUNT IS REIMBURSED TO THE HOME BY OUR COMMUNITY. THE COST OF THESE WAGES IS ADJUSTED ON PAGE 3.

PAGE 20, LINE 20

THE ADMINISTRATOR'S POSITION IS FILLED BY RELIGIOUS PERSONS WHO RECEIVE NO PERSONAL REMUNERATION, BUT WHOSE EVALUATED SERVICES HAS BEEN INCLUDED ON PAGE 3, LINE 17, COL 3.

RECONCILIATION OF DEPRECIATION EXPENSE

SCHEDULE V, LINE 30	<u>COL 4</u>	<u>ADJUST</u>	<u>COL 8</u>
NON-CARE ASSETS DEPRECIATION	\$ 131,989	\$ (6,481)	\$ 125,508
ADJUST PY DEPRECIATION	(12,621)	12,621	-
ADJUSTMENTS TO STRAIGHT LINE	1,365		1,365
PORTION OF DEPRECIATION ALLOCABLE TO WORKING SISTERS HOUSED IN HOME		(1,100)	-
SCHEDULE XI, PAGE 13, SEC E, LINE 82	5,040	(5,040)	-
SCHEDULE XI, PAGE 13, SEC E, LINE 83	<u>\$ 125,773</u>	-	<u>\$ 126,873</u>

SCHEDULE V

PAGE 3, LINE 25 - Other Admin. Staff Travel

Monthly Mileage	Home		Non Allowable	
	Related	Related	Sisters Personal	Fee
July	696.40	46.60	927.40	85.00
August	886.80	53.10	933.70	86.00
September	423.50	19.70	483.50	47.00
October	526.40	28.40	910.80	84.00
November	345.40	50.80	399.30	57.00
December	330.10	34.10	728.60	64.00
January	349.00	60.30	565.50	52.00
February	275.10	107.80	221.70	21.00
March	175.50	45.60	198.70	20.00
April	100.80	96.10	457.10	47.00
May	218.60	85.30	650.50	72.00
June	236.80	52.40	389.00	44.00
<b>TOTALS</b>	<b>4,564.40</b>	<b>680.20</b>	<b>6,865.80</b>	<b>679.00</b>

Mileage rate	\$ 0.375	\$ 0.375	\$ 0.140
Home mileage	\$ 1,712		
Medical mileage		255	
Fees		679	
Other nominal expenses		107	
TOTAL PAGE 3, LINE 25, COL 8	<u>\$ 2,753</u>		

ST. JOSEPH'S HOME HAS BEEN REIMBURSED FOR THE SISTERS' EXPENSES BY ITS MOTHER HOUSE

Facility Name & ID Number      ST. JOSEPH'S HOME OF PEORIA      # 0013862      Report Period Beginning: 07/01/2003      Ending: 06/30/2004

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**SCHEDULE OF BOARD OF DIRECTORS**

Sister Ann Regina Hughes, President  
Immaculate Conception Convent  
2408 West Heading Avenue  
West Peoria, IL 61604

\* Tom Nauman  
920 W. Butterfield Drive  
Peoria, IL 61614

Sister Mary Elaine Haertjens  
Immaculate Conception Convent  
2408 West Heading Avenue  
West Peoria, IL 61604

Paul Reardon  
1500 W. Queenscourt Rd.  
Peoria, IL 61614

Joan Ausbury  
303 Oakbrook Drive  
East Peoria, IL 61611

Patrick Smarjesse  
5620 North Woodland Ct.  
Peoria, IL 61614

Tom Dermody  
4929 N. Woodview Avenue  
Peoria, IL 61614

Ken Zika  
12202 Wake Robin Way  
Dunlap, IL 61525

Bob Ferlmann  
12320 North Lake Forest  
Dunlap, IL 61525

Ed Monroe  
316 West Ridgemont Road  
Peoria, IL 61614

\*Board member Thomas Nauman owns Nauman, Inc. The Corporation is hired to do mechanical control work on the home's broilers and air handlers. The home paid Nauman, Inc \$13,690 during the fiscal year ended June 30, 2004.

**Davis & Campbell L.L.C.**

1/26/2004	\$	540	Legal work for NLRB
2/23/2004		1,031	Legal work for NLRB/guardianship/DNR research
3/29/2004		4,409	Legal work for NLRB/DNR & witness questions/POA forms
4/27/2004		12	Legal work for Westlaw charges
5/26/2004		2,327	Legal work for union negotiations/personnel issues
6/28/2004		<u>6,295</u>	Legal work for union negotiations/personnel handbook/addendum

Total    \$                      14,614

Disallowed    13,730

Total allowable legal expense                      \$                      884

See attached invoices.