

		FOR BHF USE					

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2006
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2006)

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.

I. IDPH Facility ID Number: 0005520

Facility Name: MOUNT ST JOSEPH

Address: 24955 NORTH HIGHWAY 12 LAKE ZURICH 60047
 Number City Zip Code

County: LAKE

Telephone Number: 847-438-5050 **Fax #** 847-719-1060

HFS ID Number: 36-2639774001

Date of Initial License for Current Owners: 1947

Type of Ownership:

<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

In the event there are further questions about this report, please contact:
Name: DON LASCO **Telephone Number:** 847-438-5050

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/1/05 to 6/30/06 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.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed) _____	(Date) _____
	(Type or Print Name) _____	(Title) _____
Paid Preparer	(Signed) _____	(Date) _____
	(Print Name and Title) _____	
	(Firm Name & Address) _____	
	(Telephone) () _____ Fax # () _____	

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
 201 S. Grand Avenue East
 Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number MOUNT ST JOSEPH

0005520 Report Period Beginning: 7/1/05 Ending: 6/30/06

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment			
		Medicaid Recipient	Private Pay	Other	
8	SNF				8
9	SNF/PED				9
10	ICF				10
11	ICF/DD	43,737	714		44,451
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	43,737	714		44,451

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.26%

D. How many bed-hold days during this year were paid by the Department? 1,785 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
NONE

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

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

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

I. On what date did you start providing long term care at this location?
Date started 1947

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

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

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 6/30/06 Fiscal Year: 6/30/06

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

Facility Name & ID Number MOUNT ST JOSEPH # 0005520 Report Period Beginning: 7/1/05 Ending: 6/30/06

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	94,100		8,722	102,822		102,822	(10,282)	92,540			1
2	Food Purchase		175,554		175,554		175,554	(17,555)	157,999			2
3	Housekeeping	235,234	10,155		245,389		245,389		245,389			3
4	Laundry	50,978	9,250		60,228		60,228		60,228			4
5	Heat and Other Utilities			241,638	241,638		241,638	(12,082)	229,556			5
6	Maintenance	164,257	83,191	292,970	540,418		540,418		540,418			6
7	Other (specify):* RENTED SPACE							(33,600)	(33,600)			7
8	TOTAL General Services	544,569	278,150	543,330	1,366,049		1,366,049	(73,519)	1,292,530			8
	B. Health Care and Programs											
9	Medical Director	27,298			27,298		27,298		27,298			9
10	Nursing and Medical Records	2,232,798	43,844	31,368	2,308,010	(29,900)	2,278,110		2,278,110			10
10a	Therapy	88,089			88,089	(6,612)	81,477	(6,000)	75,477			10a
11	Activities											11
12	Social Services	79,177			79,177		79,177		79,177			12
13	CNA Training					29,900	29,900		29,900			13
14	Program Transportation		34,967		34,967		34,967		34,967			14
15	Other (specify):* DAY TRAINING	261,176	19,394	131,940	412,510		412,510	(412,510)				15
16	TOTAL Health Care and Programs	2,688,538	98,205	163,308	2,950,051	(6,612)	2,943,439	(418,510)	2,524,929			16
	C. General Administration											
17	Administrative	108,000	19,167		127,167		127,167		127,167			17
18	Directors Fees											18
19	Professional Services			43,822	43,822		43,822		43,822			19
20	Dues, Fees, Subscriptions & Promotions			10,407	10,407		10,407		10,407			20
21	Clerical & General Office Expenses	159,701	22,748	5,525	187,974		187,974		187,974			21
22	Employee Benefits & Payroll Taxes			586,509	586,509		586,509	(17,226)	569,283			22
23	Inservice Training & Education											23
24	Travel and Seminar			280	280		280		280			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			87,451	87,451		87,451		87,451			26
27	Other (specify):*											27
28	TOTAL General Administration	267,701	41,915	733,994	1,043,610		1,043,610	(17,226)	1,026,384			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,500,808	418,270	1,440,632	5,359,710	(6,612)	5,353,098	(509,255)	4,843,843			29

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

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

Facility Name & ID Number MOUNT ST JOSEPH

#0005520

Report Period Beginning:

7/1/05

Ending:

6/30/06

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			338,304	338,304		338,304	29,407	367,711			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			180,000	180,000		180,000	(180,000)				34
35	Rent-Equipment & Vehicles					6,612	6,612		6,612			35
36	Other (specify):*											36
37	TOTAL Ownership			518,304	518,304	6,612	524,916	(150,593)	374,323			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			342,144	342,144		342,144		342,144			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			342,144	342,144		342,144		342,144			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,500,808	418,270	2,301,080	6,220,158		6,220,158	(659,848)	5,560,310			45

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

Facility Name & ID Number MOUNT ST JOSEPH

0005520

Report Period Beginning: 7/1/05

Ending: 6/30/06

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	(27,837)	L1&2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space	(33,600)	L7		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(51,603)	L30		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(6,000)	L10a		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals	(412,510)	L15		23
24	Bad Debt	(17,226)	L22		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(12,082)	L5		28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (560,858)		\$	30

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

		1	2	
		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)	(98,990)	VII L14	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (98,990)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (659,848)		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					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY					
48		49		50	
				51	
					52

MOUNT ST JOSEPH

ID# 0005520

Report Period Beginning: 7/1/05

Ending: 6/30/06

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1		\$		1
2				2
3				3
4	NON-PATIENT MEALS	(27,837)	L1 & L2	4
5				5
6	RENTED FACILITY SPACE	(33,600)	L34	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14	DEPRECIATION	(51,603)	L30	14
15				15
16				16
17	PRIEST STIPEND	(6,000)	L10a	17
18				18
19				19
20				20
21				21
22				22
23	DAY TRAINING	(412,510)	L15	23
24	DAY TRAINING P/R TAX	(17,226)	L22	24
25				25
26				26
27				27
28	UTILITIES	(12,082)	L5	28
29				29
30	SUBTOTAL (A): (Sum of lines 1-29)	(560,858)		30
31				31
32				32
33				33
34	COSTS (SCHEDULE VII)	-98,900	VII L14	34
35				35
36	SUBTOTAL (B):	-98,990		36
37	TOTAL ADJUSTMENTS (A_ and (B)	-659,848		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	(1,979,454)		49

STATE OF ILLINOIS

Facility Name & ID Number MOUNT ST JOSEPH

0005520

Report Period Beginning:

7/1/05

Ending:

Summary B

6/30/06

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)	
	D. Ownership													
30	Depreciation	0	81,010	0	0	0	0	0	0	0	0	0	81,010	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	(180,000)	0	0	0	0	0	0	0	0	0	(180,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	0	(98,990)	0	0	0	0	0	0	0	0	0	(98,990)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	0	(98,990)	0	0	0	0	0	0	0	0	0	(98,990)	45

Facility Name & ID Number MOUNT ST JOSEPH

0005520

Report Period Beginning:

7/1/05

Ending:

6/30/06

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
DAUGHTERS OF ST. MARY OF PROVIDENCE	100					

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: 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	34 RENT	\$ (180,000)	DAUGHTERS OF ST. MARY OF PROVIDENCE	100.00%	\$	\$ (180,000)	1
2	V	30 DEPRECIATION	81,010	DAUGHTERS OF ST. MARY OF PROVIDENCE	100.00%		81,010	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		\$ (98,990)			\$	\$ * (98,990)	14

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

Facility Name & ID Number

MOUNT ST JOSEPH

#

0005520

Report Period Beginning:

7/1/05

Ending:

6/30/06

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	SR. GERTRUDE LABARBER	SUPERIOR	C.E.O.	0.00	0	84	100.00	SALARY	\$ 72,000	L17 C1	1
2	SR. MARY WALKER	ADMINISTRATOR	DIRECTOR	0.00	0	84	100.00	SALARY	36,000	L17 C1	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 108,000		13

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

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

Facility Name & ID Number MOUNT ST JOSEPH

0005520

Report Period Beginning:

7/1/05

Ending:

6/30/06

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 N/A

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					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	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									

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

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

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 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 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME MOUNT ST JOSEPH COUNTY LAKE

FACILITY IDPH LICENSE NUMBER 0005520

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2005 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 2005.

(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 original 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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

Facility Name & ID Number MOUNT ST JOSEPH

0005520 Report Period Beginning:

7/1/05 Ending:

6/30/06

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 147,565 B. General Construction Type: Exterior BRICK Frame BRICK Number of Stories 2

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

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

DEVELOPMENTAL TRAINING 1,010 SQ. FEET

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	<u>HOME & FARM</u>	<u>6,969,600</u>	<u>1935</u>	<u>\$ 8,000</u>	1
2					2
3	TOTALS	6,969,600		\$ 8,000	3

Facility Name & ID Number MOUNT ST JOSEPH

0005520

Report Period Beginning:

7/1/05

Ending:

6/30/06

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	132			1969	\$ 5,007,009	\$		\$	\$	\$ 5,007,009	4
5											5
6				1990	2,361,653	78,720	30	78,720		1,298,882	6
7				1990	68,729	2,290	30	2,290		37,785	7
8											8
Improvement Type**											
9	LAND IMPROVEMENTS-PRIOR YEARS:			1993	29,005						9
10				1994	93,489						10
11				1995	44,713						11
12				1996	18,082						12
13				1997	42,570						13
14				1998	17,423						14
15				1999	21,853						15
16				2001	4,700	19,834		19,834		233,763	16
17											17
18	BUILDING IMPROVEMENTS-PRIOR YEARS			1991	74,205						18
19				1992	90,293						19
20				1993	180,181						20
21				1994	178,251						21
22				1995	231,228						22
23				1996	82,875						23
24				1997	71,814						24
25				1998	116,448						25
26				1999	121,823						26
27				2000	37,015						27
28				2001	76,812						28
29				2002	112,086	231,614		231,614		1,400,501	29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number MOUNT ST JOSEPH

0005520

Report Period Beginning:

7/1/05

Ending:

6/30/06

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	LAND IMPROVEMENTS		\$	\$		\$	\$	\$	37
38	LANDSCAPING	5-Aug	17,048						38
39	LANDSCAPING & PLANTS	6-Jun	9,230						39
40									40
41	BUILDING IMPROVEMENTS								41
42	ST. JOSEPH REMODEL & PAINT	5-Jul	14,964						42
43	BARN/REMODEL,PAINT & NEW ROOF	5-Aug	114,140						43
44	THERAPY/REMODEL & NEW CABINETS	5-Sep	20,421						44
45	THERAPY CENTER PLUMBING	5-Sep	37,253						45
46	ADMINISTRATION/FILTER SYSTEM & PLUMBING	5-Sep	32,500						46
47	MEDICAL RECORDS/REMODEL & NEW CABINETS	5-Oct	28,259						47
48	DENTAL OFFICE/PLUMBING & COMPRESSOR	5-Nov	16,193						48
49	NURSES STATION/REMODEL & PAINT	5-Nov	21,140						49
50	FACILITY/NEW WINDOWS	5-Dec	116,318						50
51	VILLA/NEW FLOOR TILE	6-Jan	9,624						51
52	KITCHEN/ELECTRIC SERVICE	6-Feb	15,035						52
53	KITCHEN/REMODEL	6-Mar	5,802						53
54	KITCHEN/ELECTRICAL WORK	6-Mar	88,000						54
55	ST. ROSE/REMODEL	6-Jun	60,611						55
56	KITCHEN/ELECTRICAL SERVICE	6-Jun	41,500						56
57	THERAPY/NEW ENTRANCE	6-Jun	16,310						57
58	BARN/SIDING	6-Apr	38,585						58
59									59
60	FACILITY/STONE PIERS & WALL	6-Jun	67,785						60
61	SACRED HEART/REPAIRS & NEW ROOF	6-Feb	69,957						61
62	NURSES STATION/ROOF	6-Feb	19,760						62
63	NURSES STATION/FIRE DOORS	6-Feb	12,280						63
64	CHAPEL/NEW ROOF	6-Jun	37,000						64
65	THERAPY/VINYL FLOOR	6-Feb	6,400						65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 9,998,372	\$ 332,458		\$ 332,458	\$	\$ 7,977,940	70

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

Facility Name & ID Number MOUNT ST JOSEPH

0005520

Report Period Beginning:

7/1/05

Ending:

6/30/06

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	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 9,998,372	\$ 332,458		\$ 332,458	\$	\$ 7,977,940	1
2	BUILDING IMPROVEMENTS								2
3	AUTOMATIC TANK GAUGING SYSTEM	2-Jul	13,167						3
4	CARLSON HALL STEAM LINE	2-Jul	1,913						4
5	CLEAN STEAM BOILERS	2-Nov	4,740						5
6	2 UNIT HEATERS/GARAGE	2-Dec	6,145						6
7	HOT WATER HEATER/ANGEL GUARDIAN	2-Dec	9,084						7
8	PENTAIR HEATERS/POOL	2-Oct	5,481						8
9	THERAPY CENTER/ROOF WORK	3-May	2,100						9
10	TWO REST ROOMS	3-Jan	32,000						10
11	REPLACE RADIANT IN BASEMENT	3-Feb	3,633						11
12	REPAIR SEWER IN CRAWL SPACE	3-Mar	4,714						12
13	ARCHITECTURAL SKETCH PLANS	3-Apr	2,640						13
14	FLOOR PANELS/KITCHEN	3-May	12,830						14
15	SPEED CONTROLS/THERAPY	3-Jun	5,728						15
16	TRANSFER LIFT/THERAPY	3-Jun	6,448						16
17	AIR CONDITIONER/ADMINISTRATION	3-Jun	124,900						17
18	AIR CONDITIONING/WIRING	3-Jun	14,600						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	TOTAL (lines 1 thru 33)		\$ 10,248,495	\$ 332,458		\$ 332,458	\$	\$ 7,977,940	34

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

Facility Name & ID Number MOUNT ST JOSEPH

0005520

Report Period Beginning:

7/1/05

Ending:

6/30/06

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 10,248,495	\$ 332,458		\$ 332,458	\$	\$ 7,977,940	1
2	BUILDING IMPROVEMENTS								2
3	WALK-IN COOLER/KITCHEN	3-Sep	6,190						3
4	AIR CONDITIONER/NOVITIATE	3-Oct	105,000						4
5	AIR CONDITIONER UNITS/NOVITIATE	3-Oct	1,800						5
6	FIRE ALARM/ANGEL GUARDIAN	3-Nov	4,800						6
7	SUBMERSIBLE PUMP	3-Nov	2,196						7
8	AIR COMPRESSOR	3-Dec	4,955						8
9	DRAIN & WATER CLOSET & SEWER/KITCHEN	3-Dec	12,567						9
10	CONDENSATE PUMP/ANGELINA	4-Jan	2,989						10
11	FIRE ALARM/SACRED HEART	4-Jan	3,448						11
12	NEW ROOF/GUANELLA HALL	4-Jan	36,237						12
13	AUTOMATIC DOOR/KITCHEN	4-Feb	8,032						13
14	2 COOLERS/KITCHEN	4-Mar	30,000						14
15	WALK-IN UNITS/KITCHEN	4-Mar	54,160						15
16	AUTOMATIC DOOR/THERAPY	4-Apr	6,736						16
17	GAS LINE/KITCHEN	4-Apr	3,708						17
18	AIR COMPRESSOR	4-May	1,809						18
19	AIR CONDITIONER/SACRED HEART	4-May	6,300						19
20	AIR CONDITIONER/ADMINISTRATION	4-May	12,290						20
21	HOT WATER LINE/MARCELLINA	4-Jun	4,273						21
22	COOLER WIRING/KITCHEN	4-Jun	1,890						22
23	TEST BALANCE/KITCHEN	4-Jun	18,820						23
24	AIR CONDITIONER/ADMINISTRATION	4-Jun	4,446						24
25	AIR CONDITIONER/KITCHEN	4-Apr	11,794						25
26	WALK-IN COOLER/KITCHEN	4-Jun	45,000						26
27	CONTROL VALVES/CRAWL SPACE	4-Jun	3,659						27
28	FREEZER COOLER WIRING/KITCHEN	4-Jun	9,000						28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,650,594	\$ 332,458		\$ 332,458	\$	\$ 7,977,940	34

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

Facility Name & ID Number MOUNT ST JOSEPH

0005520

Report Period Beginning:

7/1/05

Ending:

6/30/06

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 10,650,594	\$ 332,458		\$ 332,458	\$	\$ 7,977,940	1
2	BUILDING IMPROVEMENTS								2
3	DRAIN LINE/KITCHEN	4-Aug	3,901						3
4	CARPET/ADMINISTRATION	4-Aug	15,502						4
5	AIR CONDITIONER/ADMINISTRATION	4-Aug	5,112						5
6	INSPECT & CLEAN BOILERS	4-Sep	4,227						6
7	MOP SINK/ADMINISTRATION	4-Sep	3,630						7
8	ELECTRICAL/VILLA	4-Sep	16,000						8
9	REMODEL COOLER/KITCHEN	4-Sep	51,662						9
10	BOILER ROOM ROOF	4-Sep	23,741						10
11	ARCHITECTURAL SERVICE/KITCHEN	4-Sep	4,500						11
12	WALK-IN UNITS/KITCHEN	4-Sep	12,105						12
13	REPLACE SEWER PIPE/ST. MARY	4-Oct	15,740						13
14	GARAGE DOOR	4-Oct	4,312						14
15	EXHAUST FAN/ADMINISTRATION	4-Nov	2,945						15
16	WELL WATER PUMP	4-Nov	9,968						16
17	PERMIT FEE/KITCHEN	4-Dec	2,332						17
18	WATER COIL	4-Dec	7,940						18
19	REPAIR RECTORY BUILDING	4-Dec	18,588						19
20	PREPAIR WATER MAIN	5-Jan	32,076						20
21	AIR COMPRESSOR	5-Jan	10,651						21
22	REPAIR GENERATOR	5-Feb	1,880						22
23	ELECTRICAL WORK/THERAPY	5-Feb	12,405						23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,909,811	\$ 332,458		\$ 332,458	\$	\$ 7,977,940	34

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

Facility Name & ID Number MOUNT ST JOSEPH

0005520

Report Period Beginning:

7/1/05

Ending:

6/30/06

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	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 10,909,811	\$ 332,458		\$ 332,458	\$	\$ 7,977,940	1
2	LAND IMPROVEMENT								2
3	TREE SERVICE	5-Mar	3,300						3
4	TREE SERVICE	5-Jun	2,400						4
5									5
6	BUILDING IMPROVEMENTS								6
7	ROOF HOUSE & GARAGE	5-Feb	19,714						7
8	LIGHT POLE/ADMINISTRATION	5-Feb	2,600						8
9	ELECTRICAL WORK/ADMINISTRATION	5-Mar	2,480						9
10	MASONRY & DRYWALL/ADMINISTRATION	5-Mar	29,840						10
11	LAMINATE CABINETS/KITCHEN	5-Mar	15,380						11
12	CABINETS/CHAPEL	5-Mar	2,800						12
13	HEAT EXCHANGER/ADMINISTRATION	5-Apr	7,000						13
14	SINK/KITCHEN	5-Apr	4,740						14
15	ROOF/THERAPY	5-May	10,859						15
16	BUMB WAITER/KITCHEN	6-Jun	2,464						16
17	REPAIRS & PAINT/ADMINISTRATION	5-Jun	14,433						17
18	WATER PIPE/ADMINISTRATION	5-Jun	9,334						18
19	ELECTRIC & SEPTIC/BARN	5-Jun	7,200						19
20	ROOF REPAIRS/ST. ALS	5-Jun	10,000						20
21	HEATING UNIT/KITCHEN	5-Jun	3,200						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	TOTAL (lines 1 thru 33)		\$ 11,057,555	\$ 332,458		\$ 332,458	\$	\$ 7,977,940	34

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

Facility Name & ID Number MOUNT ST JOSEPH # 0005520 Report Period Beginning: 7/1/05 Ending: 6/30/06

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,199,592	\$ 32,919	\$ 32,919	\$		\$ 1,131,534	71
72	Current Year Purchases	41,829						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,241,421	\$ 32,919	\$ 32,919	\$		\$ 1,131,534	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	RESIDENT TRANSPORT	2002 FORD VAN	2002	\$ 23,334	\$ 2,334	\$ 2,334	\$	10	\$ 11,670	76
77										77
78										78
79										79
80	TOTALS			\$ 23,334	\$ 2,334	\$ 2,334	\$		\$ 11,670	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)		\$ 12,330,310	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 367,711	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 367,711	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 9,121,144	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	FARM EQUIPMENT	\$ 40,316	\$	\$ 40,316	86
87	VEHICLES	493,126	24,261	346,456	87
88	NON-CARE	1,052,810	27,342	923,202	88
89					89
90					90
91	TOTALS	\$ 1,586,252	\$ 51,603	\$ 1,309,974	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.

Facility Name & ID Number MOUNT ST JOSEPH

0005520

Report Period Beginning: 7/1/05

Ending: 6/30/06

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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

If NO, see instructions.

YES NO

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

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.	_____ /2007	\$ _____
13.	_____ /2008	\$ _____
14.	_____ /2009	\$ _____

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: \$ 6,612 Description: COPY MACHINE LEASE

(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.

Facility Name & ID Number MOUNT ST JOSEPH # 0005520 Report Period Beginning: 7/1/05 Ending: 6/30/06

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA <u>40</u></p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA <u>80</u></p>
--	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)	15,500	4,800		20,300
4	Clinical Wages (b)		9,600		9,600
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$ 15,500	\$ 14,400	\$	\$ 29,900
10	SUM OF line 9, col. 1 and 2 (e)	\$ 29,900			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	12
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	8
2. From other facilities (f)	
TOTAL TRAINED	20

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care	9/1	visits	27,298					27,298	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			\$ 27,298		\$	\$		\$ 27,298	14

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

Facility Name & ID Number MOUNT ST JOSEPH# 0005520Report Period Beginning: 7/1/05

Ending:

6/30/06**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 6/30/06

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,353,297	\$ 1,353,297	1
2	Cash-Patient Deposits	87,207	87,207	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	885,868	885,868	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	242,943	242,943	5
6	Prepaid Insurance	52,812	52,812	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,622,127	\$ 2,622,127	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		8,000	13
14	Buildings, at Historical Cost		7,437,391	14
15	Leasehold Improvements, at Historical Cost	2,383,731	4,884,919	15
16	Equipment, at Historical Cost		2,851,007	16
17	Accumulated Depreciation (book methods)		(9,172,747)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,383,731	\$ 6,008,570	24
	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,005,858	\$ 8,630,697	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 77,385	\$ 77,385	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	106,782	106,782	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	222,861	222,861	30
	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 407,028	\$ 407,028	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 407,028	\$ 407,028	46
47	TOTAL EQUITY(page 18, line 24)	\$ 4,598,830	\$ 8,223,669	47
	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,005,858	\$ 8,630,697	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,648,985	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,648,985	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	949,845	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 949,845	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)	\$ 4,598,830	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number MOUNT ST JOSEPH

0005520

Report Period Beginning: 7/1/05

Ending: 6/30/06

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 5,776,697	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,776,697	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	25,200	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 25,200	23
D. Non-Operating Revenue			
24	Contributions	847,742	24
25	Interest and Other Investment Income***	23,609	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 871,351	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	DEVELOPMENTAL DAY TRAINING	496,755	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 496,755	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,170,003	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,366,049	31
32	Health Care	2,943,439	32
33	General Administration	1,043,610	33
B. Capital Expense			
34	Ownership	524,916	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	342,144	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,220,158	40
41	Income before Income Taxes (line 30 minus line 40)**	949,845	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 949,845	43

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

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

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

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

Facility Name & ID Number MOUNT ST JOSEPH

0005520

Report Period Beginning: 7/1/05

Ending: 6/30/06

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing		\$	\$	1	
2	Assistant Director of Nursing				2	
3	Registered Nurses	31,726	31,826	475,797	14.95	3
4	Licensed Practical Nurses	5,475	5,577	76,968	13.80	4
5	CNAs & Orderlies	2,400	2,451	26,964	11.00	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	4,800	4,863	58,748	12.08	9
10	Activity Assistants	3,258	3,315	29,341	8.85	10
11	Social Service Workers	4,835	4,939	79,177	16.03	11
12	Dietician					12
13	Food Service Supervisor	515	567	6,235	11.00	13
14	Head Cook	3,650	3,710	31,718	8.55	14
15	Cook Helpers/Assistants	6,308	6,323	56,147	8.88	15
16	Dishwashers	19,890	20,090	261,176	13.00	16
17	Maintenance Workers	15,725	15,794	164,257	10.40	17
18	Housekeepers	27,852	28,172	235,234	8.35	18
19	Laundry	5,300	5,377	50,978	9.48	19
20	Administrator	4,582	4,621	72,000	15.58	20
21	Assistant Administrator	3,152	3,172	36,000	11.35	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,595	12,797	159,701	12.48	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director	1,540	1,560	27,298	17.50	27
28	Qualified MR Prof. (QMRP)	11,374	11,399	142,607	12.51	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	81,294	81,594	1,495,612	18.33	30
31	Medical Records	1,055	1,080	14,850	13.75	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	247,326	249,227	\$ 3,500,808 *	\$ 14.05	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	186	\$ 8,722	L 1 C3	35
36	Medical Director				36
37	Medical Records Consultant	45	1,808	L10 C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	33	1,736	L10 C3	40
41	Occupational Therapy Consultant	21	1,236	L10 C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) <u>DENTIST</u>	167	8,345	L10 C3	46
47	<u>PSYCHOLOGIST</u>	202	17,127	L10 C3	47
48	<u>PODIATRIST</u>	18	1,116	L10 C3	48
49	TOTAL (lines 35 - 48)	672	\$ 40,090		49

C. CONTRACT NURSES

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

Facility Name & ID Number MOUNT ST JOSEPH

0005520

Report Period Beginning: 7/1/05

Ending: 6/30/06

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			
GERTRUDE LABARBERA	SUPERIOR		\$ 72,000	Workers' Compensation Insurance	\$ 125,435	IDPH License Fee	\$ 200			
MARY WALKER	ADMINISTRATOR		36,000	Unemployment Compensation Insurance		Advertising: Employee Recruitment	3,061			
				FICA Taxes	270,016	Health Care Worker Background Check				
				Employee Health Insurance	99,664	(Indicate # of checks performed)				
				Employee Meals		Patient Background Checks				
				Illinois Municipal Retirement Fund (IMRF)*	91,394	LICENSE & FEES	2,057			
						DUES & SUBSCRIPTIONS	5,089			
TOTAL (agree to Schedule V, line 17, col. 1)										
(List each licensed administrator separately.)			\$ 108,000							
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**			
Description			Amount	Description	Line #	Amount	Description	Amount		
			\$			\$	Out-of-State Travel	\$		
							In-State Travel			
							Seminar Expense	280		
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL (agree to Schedule V, line 22, col.8)			\$ 586,509	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 10,407
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**		
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		
FOLISI & SAMZ	AUDITORS		\$ 26,600			\$	Out-of-State Travel	\$		
A.D.P.	PAYROLL		17,222							
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			\$	Entertainment Expense (agree to Sch. V, line 24, col. 8)		
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 43,822					TOTAL		\$ 280

* Attach copy of IMRF notifications

**See instructions.

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? NO
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 5 YEARS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 9,981 Line L10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 342,144
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? YES For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? _____ Indicate the amount. \$ _____
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? YES If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 16,281
- c. What percent of all travel expense relates to transportation of nurses and patients? 10%
- 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? YES**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: FOLISI AND SAMZ CO. The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? YES If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? LESS
Attach invoices and a summary of services for all architect and appraisal fees.

MOUNT ST. JOSEPH 000520 7/1/05-6/30/06

V. COST CENTER EXPENSES RECLASSIFICATION PAGE 3

FROM V. LINE 10 -29,900
TO V. LINE 13 29,900

TO RECLASSIFY NURSE AIDE TRAINING

FROM V. LINE 10a -6,612
TO V. LINE 35 6,612

TO RECLASSIFY RENT-EQUIPMENT

MOUNT ST. JOSEPH 000520 7/1/05-6/30/06

V. COST CENTER EXPENSES OTHER LINE 15 PAGE 3

DAY TRAINING SALARIES 261,176
DAY TRAINING SUPPLIES 19,394
DAY TRAINING BENEFITS 17,601
DAY TRAINING OCCUPANCY 48,586
DAY TRAINING TRANSPORT 58,393
DAY TRAINING RENT 2,556
DAY TRAINING DEPRECIATION 4,804 131,940
DAY TRAINING SUBTOTAL 412,510
DAY TRAINING P/R TAXES 17,226
TOTAL 429,736

VI. ADJUSTMENT DETAIL PAGE 5

NON-ALLOWABLE EXPENSES
DIETARY V. LINE 1 102,822 X .10 -10,282
FOOD PURCHASE V. LINE 2 175,554 X .10 -17,555 -27,837
RENTED SPACE V. LINE 7 -33,600
DEPRECIATION V. LINE 30 -51,603
PRIEST STIPEND V. LINE 10a -6,000
DAY TRAINING V. LINE 15 -412,510
PAYROLL TAX D/T V. LINE 22 -17,226
UTILITIES V. LINE 5 -12,082
SUBTOTAL (A) -560,858
RELATED PARTIES VII. LINE 14 -98,990
TOTAL ADJUSTMENTS (A) AND (B) -659,848

VI. ADJUSTMENT DETAIL/UTILITIES PAGE 5 SQUARE FOOTAGE

CARE RELATED AREAS:
THERAPEUTIC CENTER 29,450
OLD NURSES STATION PASSAGEWAY 6,770
ADMINISTRATIVE BUILDING 6,890
NOVITIATE & AUDITORIUM 11,120
ANGEL GUARDIAN 9,522
BOILER & LAUNDRY 4,690
CHAPEL 12,468
GARAGE 1,012
ST. MARY'S 11,691
JOSEPH'S 9,464
PASSAGEWAY 5,392
ST. ALOYIOUS 9,270
GUANELLA 15,867
KITCHEN 5,749
GARAGE 660
CHAPLAIN'S HOUSE 4,022
ADMINISTRATIVE BUILDING 2ND FLOOR 3,445
TOTAL 147,562

NON-CARE RELATED AREAS:
NOVITIATE & AUDITORIUM 5,560
FARM HOUSE 1,768
TOTAL 7,328

TOTAL SQUARE FOOTAGE 154,890

NON-CARE RELATED AREAS 7,328/154,890 0.05

TOTAL UTILITIES LINE 5 PAGE 3 241,638

TOTAL NON-CARE RELATED UTILITIES X.05 12,082

XVII. INCOME STATEMENT OTHER REVENUE PAGE 19

DEVELOPMENTAL DAY TRAINING 28a 496,755

XVII. A. STAFFING AND SALARY COSTS PAGE 20

DEVELOPMENTAL DAY TRAINING LINE 16 261,176
PSYCHOLOGY LINE 31 14,850

XX. GENERAL INFORMATION PAGE 23

COST ASSOCIATED WITH SPACE RENTAL LINE 14 NUNS QUARTERS

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