

Facility Name & ID Number ST JOSEPH NURSING HOME

0005637 Report Period Beginning: 7/1/2005 Ending: 6/30/2006

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 93

	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	93	Intermediate (ICF)	93	33,945	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	93	TOTALS	93	33,945	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		2 Medicaid Recipient	3 Private Pay	4 Other		
8	SNF					8
9	SNF/PED					9
10	ICF	17,067	11,991	216	29,274	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,067	11,991	216	29,274	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.24%

D. How many bed-hold days during this year were paid by the Department? NONE (Do not include bed-hold days in Section B.)

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 5/7/1965

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

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

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 7/1/05-6/30/06 Fiscal Year: 7/1/05-6/30/06

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

STATE OF ILLINOIS

Facility Name & ID Number **ST JOSEPH NURSING HOME** # **0005637** Report Period Beginning: **7/1/2005** Ending: **6/30/2006**

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

	Operating Expenses	Costs Per General Ledger				Reclassification 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	302,077		38,536	340,613		340,613	(44,330)	296,283		1
2	Food Purchase		214,068		214,068		214,068	#REF!	#REF!		2
3	Housekeeping	103,415	18,617		122,032		122,032		122,032		3
4	Laundry	102,528		8,373	110,901		110,901		110,901		4
5	Heat and Other Utilities			135,208	135,208		135,208	(4,998)	130,210		5
6	Maintenance	68,640		37,975	106,615		106,615		106,615		6
7	Other (specify):*										7
8	TOTAL General Services	576,660	232,685	220,092	1,029,437		1,029,437	#REF!	#REF!		8
B. Health Care and Programs											
9	Medical Director										9
10	Nursing and Medical Records	1,228,616	103,745	60,158	1,392,519		1,392,519		1,392,519		10
10a	Therapy	10,810			10,810		10,810		10,810		10a
11	Activities	57,889	7,055	33,628	98,572		98,572		98,572		11
12	Social Services	57,842	808	16,950	75,600		75,600		75,600		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,355,157	111,608	110,736	1,577,501		1,577,501		1,577,501		16
C. General Administration											
17	Administrative	87,833			87,833		87,833		87,833		17
18	Directors Fees										18
19	Professional Services			41,648	41,648		41,648		41,648		19
20	Dues, Fees, Subscriptions & Promotions			26,778	26,778		26,778	#REF!	#REF!		20
21	Clerical & General Office Expenses	121,664	15,425	35,069	172,158		172,158	#REF!	#REF!		21
22	Employee Benefits & Payroll Taxes			431,155	431,155		431,155	(7,916)	423,239		22
23	Inservice Training & Education										23
24	Travel and Seminar			6,776	6,776		6,776		6,776		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			91,257	91,257		91,257		91,257		26
27	Other (specify):*										27
28	TOTAL General Administration	209,497	15,425	632,683	857,605		857,605	#REF!	#REF!		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,141,314	359,718	963,511	3,464,543		3,464,543	#REF!	#REF!		29

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

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

Facility Name & ID Number

ST JOSEPH NURSING HOME

#0005637

Report Period Beginning:

7/1/2005

Ending:

6/30/2006

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			57,441	57,441		57,441	(32,845)	24,596			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			12,428	12,428		12,428	#REF!	#REF!			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			69,869	69,869		69,869	#REF!	#REF!			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			5,222	5,222		5,222		5,222			39
40	Barber and Beauty Shops		492	13,727	14,219		14,219		14,219			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			50,918	50,918		50,918		50,918			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		492	69,867	70,359		70,359		70,359			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,141,314	360,210	1,103,247	3,604,771		3,604,771	#REF!	#REF!			45

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

Facility Name & ID Number **ST JOSEPH NURSING HOME**

0005637

Report Period Beginning: **7/1/2005**

Ending: **6/30/2006**

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	#REF!	2		4
5	Telephone, TV & Radio in Resident Rooms	#REF!	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(31,476)	30		9
10	Interest and Other Investment Income	#REF!	32		10
11	Discounts, Allowances, Rebates & Refunds	#REF!	2		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)	#REF!	21		16
17	Non-Care Related Fees	#REF!	2		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				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	#REF!	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule SEE PAGE 5A FOR DETAILS	(86,473)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ #REF!		\$	30

BHF USE ONLY						
48		49	50	51	52	

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

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

ST JOSEPH NURSING HOME

ID# 0005637

Report Period Beginning: 7/1/2005

Ending: 6/30/2006

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Sisters' Portion of Dietary Costs	\$ (44,330)	1	1
2	Sisters' Portion of Food Costs	(27,861)	2	2
3	Sisters' Portion of Heat and Other Utilities	(4,998)	5	3
4	Sisters' Portion of Building Depreciation	(1,369)	30	4
5	Sisters' Portion of Employee Benefits in Meals	(7,916)	22	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(86,473)		49

ST. JOSEPH'S NURSING HOME, INC.
 SCHEDULE V, PAGES 3 AND 4 - OTHER RECLASSES AND ADJUSTMENTS
 YEAR ENDED JUNE 30, 2006

Patient, Sister and Employee Meals:

		Detail	Subtotals	Percentages
<i>Meals served to Patients:</i>	Patient Days (excl. bed-hold days)	29,274		
	Meals per day	3	87,822	86.99%
<i>Meals provided to Sisters (non-patient):</i>	Number of Sisters	12		
	Meals per day	3		
	Days per year	365	13,140	13.01%
	Total Meals Served		100,962	100.00%

1. Adjustments for Sisters' Maintenance:

Sisters' portion of dietary and

<i>food cost:</i>	Dietary cost	\$ 340,613	<i>From page 3, Line 1, Col. 4</i>
	Sisters' percentage	13.01%	<i>From calculation above</i>
	Sisters' Portion of Dietary Cost	\$ 44,330	<i>Adjustment: To Line 1, Schedule V</i>
	Food cost	\$ 214,068	<i>From page 3, Line 2, Col. 4</i>
	Sisters' percentage	13.01%	<i>From calculation above</i>
	Sisters' Portion of Food Cost	\$ 27,861	<i>Adjustment: To Line 2, Schedule V</i>

Sisters' portion of building and utilities:

<i>Sisters' portion of building:</i>	Convent (Sisters) Square Footage	2,464	<i>From prior year - no changes</i>
	Total Square Footage	66,656	<i>From prior year - no changes</i>
	Convent (Sisters) Offset Percentage	3.70%	

<i>Sisters' portion of utilities:</i>	Heat and Other Utilities	\$ 135,208	<i>From page 3, Line 5, Col. 4</i>
	Sisters' percentage	3.70%	<i>From calculation above</i>
	Sisters' Portion of Heat and Other Utilities	\$ 4,998	<i>Adjustment: To Line 5, Schedule V</i>

Sisters' portion of building

<i>depreciation expense:</i>	Building Depreciation Exp	\$ 37,025	<i>From G/L Account No. 782029</i>
	Sisters' percentage	3.70%	<i>From calculation above</i>
	Sister's Portion of Building Depreciation	\$ 1,369	<i>Adjustment: To Line 36, Schedule V (also see p 13 of CR)</i>

Employee Benefits in Sisters' Meals:

	Dietary Salaries	\$ 302,077	<i>From page 3, Line 1, Col. 1</i>
	Sisters' percentage	13.01%	<i>From calculation above</i>
	Salaries Applicable to Sister's Meals	\$ 39,315	
	Total Salaries	\$ 2,141,314	<i>From page 4, Line 45, Col. 1</i>
	Employee Benefits	\$ 431,155	<i>From page 3, Line 22, Col. 4</i>
	Employee benefits ratio	20.14%	
	Employee Benefits Applicable to Sister's Meals	\$ 7,916	<i>Adjustment: To Line 22, Schedule V</i>

Total Adjustments for Sisters' Portion of Costs \$ 86,473

STATE OF ILLINOIS

Summary A

Facility Name & ID Number ST JOSEPH NURSING HOME# 0005637 Report Period Beginning:

7/1/2005

Ending: 6/30/2006

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(44,330)	0	0	0	0	0	0	0	0	0	0	(44,330)	1
2	Food Purchase	#REF!	0	0	0	0	0	0	0	0	0	0	#REF!	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(4,998)	0	0	0	0	0	0	0	0	0	0	(4,998)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	#REF!	0	0	0	0	0	0	0	0	0	0	#REF!	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	#REF!	0	0	0	0	0	0	0	0	0	0	#REF!	20
21	Clerical & General Office Expenses	#REF!	0	0	0	0	0	0	0	0	0	0	#REF!	21
22	Employee Benefits & Payroll Taxes	(7,916)	0	0	0	0	0	0	0	0	0	0	(7,916)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	#REF!	0	0	0	0	0	0	0	0	0	0	#REF!	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	#REF!	0	0	0	0	0	0	0	0	0	0	#REF!	29

Facility Name & ID Number **ST JOSEPH NURSING HOME**

0005637

Report Period Beginning: **7/1/2005**

Ending: **6/30/2006**

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
THIS WORKSHEET IS NOT APPLICABLE.						

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V		\$			\$	\$	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.

Facility Name & ID Number **ST JOSEPH NURSING HOME** # **0005637** Report Period Beginning: **7/1/2005** Ending: **6/30/2006**

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									\$		1
2											2
3	THIS WORKSHEET IS NOT APPLICABLE.										
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

Facility Name & ID Number ST JOSEPH NURSING HOME # 0005637 Report Period Beginning: 7/1/2005 Ending: 7/30/2006

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					\$	\$			1
2									2
3	THIS WORKSHEET IS NOT APPLICABLE.								3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number ST JOSEPH NURSING HOME # 0005637 Report Period Beginning: 7/1/2005 Ending: 6/30/2006

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
						Amount of Note	Reporting Period Interest Expense				
Name of Lender	Related**	Purpose of Loan	Monthly Payment Required	Date of Note	Original	Balance	Maturity Date	Interest Rate (4 Digits)			
YES	NO										
A. Directly Facility Related											
Long-Term											
1	DAUGHTERS OF ST. FRANCIS OF					\$	\$			\$	1
2	ASSISI (MOTHERHOUSE)	X	WORKING CAPITAL	VARIES	VARIOUS	224,000	99,000	NONE	NONE	NONE	2
3	BANK OF LACON	X	WORKING CAPITAL	VARIES	8/11/2005	350,000	NONE	8/15/2007	9.9000	12,428	3
4											4
5											5
Working Capital											
6											6
7											7
8											8
9	TOTAL Facility Related					\$ 574,000	\$ 99,000			\$ 12,428	9
B. Non-Facility Related*											
10											10
11											11
12											12
13											13
14	TOTAL Non-Facility Related					\$	\$			\$	14
15	TOTALS (line 9+line14)					\$ 574,000	\$ 99,000			\$ 12,428	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ NONE Line # N/A

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

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

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

B. Real Estate Taxes

<div style="border: 1px solid black; padding: 2px; display: inline-block;"> Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report. </div>																											
1. Real Estate Tax accrual used on 2005 report.		\$	1																								
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	2																								
3. Under or (over) accrual (line 2 minus line 1).		\$	3																								
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	4																								
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5																								
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6																								
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	7																								
Real Estate Tax History:																											
Real Estate Tax Bill for Calendar Year:	<table border="1"> <tr><td>2001</td><td style="text-align: center;">8</td></tr> <tr><td>2002</td><td style="text-align: center;">9</td></tr> <tr><td>2003</td><td style="text-align: center;">10</td></tr> <tr><td>2004</td><td style="text-align: center;">11</td></tr> <tr><td>2005</td><td style="text-align: center;">12</td></tr> </table>	2001	8	2002	9	2003	10	2004	11	2005	12	<table border="1"> <tr><td colspan="2" style="text-align: center;">FOR BHF USE ONLY</td></tr> <tr> <td style="text-align: right;">13</td> <td>FROM R. E. TAX STATEMENT FOR 2005 \$</td> <td style="text-align: right;">13</td> </tr> <tr> <td style="text-align: right;">14</td> <td>PLUS APPEAL COST FROM LINE 5 \$</td> <td style="text-align: right;">14</td> </tr> <tr> <td style="text-align: right;">15</td> <td>LESS REFUND FROM LINE 6 \$</td> <td style="text-align: right;">15</td> </tr> <tr> <td style="text-align: right;">16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$</td> <td style="text-align: right;">16</td> </tr> </table>		FOR BHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2005 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
2001	8																										
2002	9																										
2003	10																										
2004	11																										
2005	12																										
FOR BHF USE ONLY																											
13	FROM R. E. TAX STATEMENT FOR 2005 \$	13																									
14	PLUS APPEAL COST FROM LINE 5 \$	14																									
15	LESS REFUND FROM LINE 6 \$	15																									
16	AMOUNT TO USE FOR RATE CALCULATION \$	16																									
THIS WORKSHEET IS NOT APPLICABLE.																											

NOTES:

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 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,

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME ST JOSEPH NURSING HOME COUNTY MARSHALL

FACILITY IDPH LICENSE NUMBER 0005637

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Costs

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)
Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
1. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. THIS WORKSHEET IS NOT APPLICABLE.	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ _____	\$ _____

B. Real Estate Tax Cost Allocation:

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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 66,656 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories ONE

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

NOT APPLICABLE.

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

1. Total Amount Incurred: NOT APPLICABLE. 2. Number of Years Over Which it is Being Amortized: NOT APPLICABLE.
 3. Current Period Amortization: NOT APPLICABLE. 4. Dates Incurred: NOT APPLICABLE.

Nature of Costs: NOT APPLICABLE.

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>OWNED BY DAUGHTERS</u>			\$	1
2	<u>OF ST. FRANCIS OF ASSISI</u>	<u>428,532</u>	<u>1965</u>	<u>25,700</u>	2
3	TOTALS	428,532		\$ 25,700	3

Facility Name & ID Number ST JOSEPH NURSING HOME

0005637

Report Period Beginning:

7/1/2005

Ending:

6/30/2006

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	43		1965	\$ 484,023	\$	VARIOUS	\$	\$	\$ 484,023
5	50		1969	898,293		VARIOUS			898,293
6			1968	451,401		25			451,401
7			1986	3,877		12			3,877
8			1987	5,840		15			5,840
Improvement Type**									
9	MISC		1968	6,160		50			6,160
10	GARAGE		1972	2,491		50			2,491
11	FINISH BASEMENT		1973	6,343		50			6,343
12	WINDOW		1974	900		50			900
13	INSULATION		1976	21,986		50			21,986
14	ROOF		1980	16,049		50			16,049
15	MISC REMODELING		1981	7,711		10			7,711
16	IDPA AUDIT ADJUSTMENTS		1982	1,290		10			1,290
17	IDPA AUDIT ADJUSTMENTS		1983	877		10			877
18	IDPA AUDIT ADJUSTMENTS		1984	53,742		VARIOUS			53,742
19	IDPA AUDIT ADJUSTMENTS		1985	15,330		15			15,330
20	IDPA AUDIT ADJUSTMENTS		1969	28,119		20			28,119
21	IDPA AUDIT ADJUSTMENTS		1977	11,869	222	20		(222)	6,580
22	IDPA AUDIT ADJUSTMENTS		1986	94,429		VARIOUS			94,429
23	IDPA AUDIT ADJUSTMENTS		1989	146,038	4,100	VARIOUS		(4,100)	112,105
24	DECORATING		1987	3,285		10			3,285
25	PARKING LOT		1988	19,937		VARIOUS			19,937
26	FIRE ALARM SYSTEM		1990	37,956	1,886	VARIOUS		(1,886)	29,955
27	NEW ROOF		1992	55,787		10			55,787
28	HOT WATER TANK		1992	3,295		10			3,295
29	BUILDING PAINTING		1993	7,336		5			7,336
30	ROOF REPAIRS		1993	434		10			434
31	WATER HEATER		1993	223	15	15		(15)	187
32	BOILER REPAIR		1993	1,415		10			1,415
33	CODE ALERT FIRE SYSTEM		1995	8,559	128	10		(128)	8,559
34	MISC		1997	3,013		10			3,013
35	VINYL FLOOR		1998	4,012		5			4,012
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

STATE OF ILLINOIS

Facility Name & ID Number ST JOSEPH NURSING HOME

0005637

Report Period Beginning:

7/1/2005

Ending:

6/30/2006

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	CERAMIC FLOOR FOR NEW TUB	1999	\$ 107	\$ 5	20	\$	\$ (5)	\$ 33		37
38	CARPET ON WALLS	2000	2,668	265	5		(265)	2,668		38
39	METAMORA TELEPHONE SYSTEM	2000	7,337	734	10		(734)	4,037		39
40	TOMKAT ROOFING	2001	18,760	1,876	10		(1,876)	8,442		40
41	HOBERT CORP	2001	1,555	156	10		(156)	702		41
42	ASPHALT REPAIR	2002	2,900	363	8		(363)	1,270		42
43										43
44	75 GALLON 365M ASME WTR HTR	2006	5,225	261	10	261				44
45	ULTRA CARE 709 BED LAMINATE PANELS	2006	5,809	193	15	193				45
46	HOYER PROF PATIENT LIFT	2006	3,020	151	10	151				46
47	HOYER PROF VERTICAL PATIENT LIFT W/ SCALE	2006	4,249	212	10	212				47
48										48
49										49
50										50
51										51
52										52
53										53
54										54
55										55
56										56
57										57
58										58
59										59
60										60
61										61
62										62
63										63
64										64
65										65
66										66
67										67
68										68
69										69
70	TOTAL (lines 4 thru 69)		\$ 2,453,650	\$ 10,567		\$ 817	\$ (9,750)	\$ 2,371,823		70

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

Facility Name & ID Number **ST JOSEPH NURSING HOME** # **0005637** Report Period Beginning: **7/1/2005** Ending: **6/30/2006**

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	\$ 158,653	\$ 44,483	\$ 22,757	\$ (21,726)		\$ 83,993	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	465,884					465,884	73
74								74
75	TOTALS	\$ 624,537	\$ 44,483	\$ 22,757	\$ (21,726)		\$ 549,877	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	NURSING HOME	CHEVY CAPRICE	1987	\$ 10,289	\$	\$	\$		\$ 10,289	76
77	NURSING HOME	PICK-UP	1995	14,590					14,590	77
78	NURSING HOME	MISC. OTHER	VARIOUS	5,676					5,676	78
79	NURSING HOME	2001 DODGE RAM 3500 VAN	2002	19,135	2,391	2,391			16,744	79
80	TOTALS			\$ 49,690	\$ 2,391	\$ 2,391	\$		\$ 47,299	80

E. Summary of Care-Related Assets

	1	Reference	2	Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$	3,153,577	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	57,441	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$	25,965	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	(31,476)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$	2,968,999	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	SISTERS SHARE OF BUILDING	\$ 63,491	\$	\$ 63,491	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 63,491	\$	\$ 63,491	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: THIS WORKSHEET IS NOT APPLICABLE.
 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.	<u>/2007</u>	\$ _____
13.	<u>/2008</u>	\$ _____
14.	<u>/2009</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: \$ _____ Description: _____
 (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe 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.

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (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	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 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				THIS WORKSHEET IS NOT APPLICABLE.							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 prescripts											9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs											10
11	Academic Education		hrs											11
12	Exceptional Care Program													12
13	Other (specify):													13
14	TOTAL			\$		\$		\$		\$			\$	14

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

STATE OF ILLINOIS

Page 17

Facility Name & ID Number ST JOSEPH NURSING HOME

0005637

Report Period Beginning: 7/1/2005

Ending:

6/30/2006

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/2006

(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	\$ 696,945	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 5,642)	306,824		3
4	Supply Inventory (priced at)	16,615		4
5	Short-Term Investments			5
6	Prepaid Insurance	1,936		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Contribution Receivable	750,000		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,772,320	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	79,003		13
14	Buildings, at Historical Cost	1,542,375		14
15	Leasehold Improvements, at Historical Cost	208,782		15
16	Equipment, at Historical Cost	1,264,872		16
17	Accumulated Depreciation (book methods)	(2,638,834)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 456,198	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,228,518	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 60,999	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	150,130		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	DEFERRED REVENUE	47,808		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 258,937	\$	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	DUE TO MOTHERHOUSE	99,000		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 99,000	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 357,937	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,870,581	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,228,518	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 653,218	1
2	Restatements (describe):		2
3	Prior Period Adjustment - Refer to Footnote 11 in the		3
4	attached 2006 Audited Financial Statements for		4
5	details.	(263,366)	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 389,852	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	1,480,729	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)	\$ 1,480,729	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)	\$ 1,870,581	24 *

* This must agree with page 17, line 47.

STATE OF ILLINOIS

Facility Name & ID Number ST JOSEPH NURSING HOME

0005637

Report Period Beginning: 7/1/2005

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

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,546,644	1
2	Discounts and Allowances for all Levels	(1,319,792)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,226,852	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	827	12
13	Barber and Beauty Care	18,435	13
14	Non-Patient Meals	9,996	14
15	Telephone, Television and Radio	3,681	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	9,580	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 42,519	23
D. Non-Operating Revenue			
24	Contributions	1,779,981	24
25	Interest and Other Investment Income***	10,966	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,790,947	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	SISTERS' MAINTENANCE	25,182	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 25,182	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,085,500	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,029,437	31
32	Health Care	1,577,501	32
33	General Administration	857,605	33
B. Capital Expense			
34	Ownership	69,869	34
C. Ancillary Expense			
35	Special Cost Centers	19,441	35
36	Provider Participation Fee	50,918	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,604,771	40
41	Income before Income Taxes (line 30 minus line 40)**	1,480,729	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,480,729	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 **ST JOSEPH NURSING HOME**# **0005637**Report Period Beginning: **7/1/2005**Ending: **6/30/2006****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	2,873	3,190	\$ 81,054	\$ 25.41	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,034	8,226	170,103	20.68	3
4	Licensed Practical Nurses	12,394	13,876	235,995	17.01	4
5	CNAs & Orderlies	54,753	62,174	612,473	9.85	5
6	CNA Trainees	2,215	2,511	20,283	8.08	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,119	2,275	39,934	17.55	8
9	Activity Director	1,872	2,170	26,465	12.20	9
10	Activity Assistants	3,113	3,883	32,953	8.49	10
11	Social Service Workers	1,787	2,175	26,863	12.35	11
12	Dietician					12
13	Food Service Supervisor	1,894	2,170	40,120	18.49	13
14	Head Cook	8,845	10,193	81,512	8.00	14
15	Cook Helpers/Assistants	7,785	8,732	64,423	7.38	15
16	Dishwashers	12,816	14,880	120,993	8.13	16
17	Maintenance Workers	3,671	4,375	70,685	16.16	17
18	Housekeepers	12,348	14,125	109,237	7.73	18
19	Laundry	10,101	12,011	102,547	8.54	19
20	Administrator	1,844	2,170	90,047	41.50	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,956	2,170	32,068	14.78	23
24	Clerical	6,438	7,681	93,379	12.16	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	1,620	1,951	20,157	10.33	31
32	Other Health Care MDS COORDINA	1,722	1,857	35,639	19.19	32
33	Other(specify) SOC. SERV. DIR	1,874	2,209	34,384	15.57	33
34	TOTAL (lines 1 - 33)	161,074	185,004	\$ 2,141,314 *	\$ 11.57	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	146	\$ 3,641	1.3	35
36	Medical Director				36
37	Medical Records Consultant	36	1,515	10.3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	154	1,000	10.3	39
40	Physical Therapy Consultant	10	249	10.3	40
41	Occupational Therapy Consultant	21	1,754	10.3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	24	1,410	11.3	44
45	Social Service Consultant	24	1,410	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	415	\$ 10,979		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

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	
THOMAS E. BECHER	ADMINISTRATOR	0	\$ 87,833	Workers' Compensation Insurance	\$ 0	IDPH License Fee	\$ 9,478	
				Unemployment Compensation Insurance	8,798	Advertising: Employee Recruitment	9,478	
				FICA Taxes	169,918	Health Care Worker Background Check (Indicate # of checks performed _____)		
				Employee Health Insurance	238,894	Patient Background Checks		
				Employee Meals	0			
				Illinois Municipal Retirement Fund (IMRF)*	0	DUES AND LICENSES	17,300	
				OTHER EMPLOYEE BENEFITS	13,545			
				Less Sisters Maintenance Adjustment	(7,916)			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 87,833			Less: Public Relations Expense	(1,842)	
B. Administrative - Other						Non-allowable advertising ()		
Description			Amount			Yellow page advertising ()		
THIS SCHEDULE IS NOT APPLICABLE.			\$ 0					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 0	TOTAL (agree to Schedule V, line 22, col.8)	\$ 423,239	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 24,936	
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
Accu-Med Services	Computer Services		4,726	THIS SCHEDULE IS NOT APPLICABLE.			Out-of-State Travel	\$ 0
Achieve Software Corp.	Computer Software		5,689					
Alliance Benefit Group	Benefits Consulting		4,400				In-State Travel	488
Catholic Mutual Group	Insurance Fee		2,500				VEHICLE MAINT. AND GAS	2,324
CBIZ, Inc.	Accounting Services		6,100				Seminar Expense	3,964
Dr. Kaplan, DDS	Dental Services		1,824					
Fidelity on Call	Nursing Temp Agency		3,933				Entertainment Expense ()	
MSW Projects	Computer Services		600				(agree to Sch. V, line 24, col. 8)	
Kronos	Payroll Software		2,018				TOTAL	\$ 6,776
Mayer Hoffman McCann, P.C.	Audit Services		8,570					
Red Wing Business Solutions	Network Support		521					
Others (less than \$500 each)	Various		767					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 41,648	TOTAL		\$		

* Attach copy of IMRF notifications

**See instructions.

ST. JOSEPH'S NURSING HOME
SCHEDULE XIX, G, PAGE 21
SCHEDULE OF SEMINAR EXPENSE
Year Ended June 30, 2006

<u>Seminar Name</u>	<u>Employee(s)</u>	<u>Date</u>	<u>Cost</u>
Illinois Nursing Home Admin Assoc.	Becher/Colwell	09/30/05	\$95
Illinois Nursing Home Admin Assoc.	Becher	01/28/06	\$95
Illinois Nursing Home Admin Assoc.	Becher/Colwell	02/09/06	\$95
Peoria Health Department	Marilee Pelphrey	07/22/05	\$60
Life Services Network - Medicaid	Becher/Colwell	07/31/05	\$250
Methodist Medical Center	Whitney/Colwell	09/09/05	\$100
Illinois Nursing Home Admin Assoc.	Becher/Whitney	09/30/05	\$95
Life Services Network	Whitney	10/04/05	\$198
Life Services Network	Whitney/Colwell/Quigg	10/10/05	\$285
Land of Lincoln College	Kissee/Sister Michael	10/31/05	\$430
American Red Cross	Whitney	10/31/05	\$437
Illinois Nursing Home Admin Assoc.	Becher/Colwell	01/28/06	\$95
Illinois Nursing Home Admin Assoc.	Becher/Colwell	02/09/06	\$190
Rhonda Polzin	Sampo	04/07/06	\$140
Ramirez Consulting	Sampo/Colwell	04/20/06	\$150
Land of Lincoln College	Kissee/Sister Michael	04/30/05	\$80
Great Seminars & Books	Annette Lionberger	05/31/06	\$495
Institutue of Physical Rehab	Annette Lionberger	11/30/05	\$300
Rhonda Polzin	Sampo	04/07/06	\$35
Social Services Organization	Sampo	12/21/05	\$59
Illinois Nursing Home Admin Assoc.	Becker/Colwell	02/09/06	\$95
Rhonda Polzin	Sampo	04/07/06	\$35
Ramirez Consulting	Colwell	04/20/06	\$150
Total Seminar Expense			<u><u>\$3,964</u></u>

Facility Name & ID Number ST JOSEPH NURSING HOME

0005637

Report Period Beginning: 7/1/2005

Ending: 6/30/2006

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. Catholic Health Assoc., AAHSA, Life Services Network, Lacon Chamber of Commerce
- (3) Did the nursing home make political contributions or payments to a political organization? NO If YES, have these costs been properly adjusted out of the cost report? N/A
- (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? N/A
- (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. \$ 22,772 Line 10.2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. N/A
- (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 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 N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 50,918
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-SEE ADJUST. 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 benefit: on Schedule V. \$ 0 Has any meal income been offset against related costs? YES Indicate the amount. \$ 9,996
- (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. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? NONE
- d. Have vehicle usage logs been maintained? N/A
- 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? N/A
- 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. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: Mayer Hoffman McCann, P.C. 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. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES, TO THE BEST OF OUR KNOWLEDGE.
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

END OF FISCAL 2006 COST REPORT