

		FOR BHF USE					

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2007
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2007)

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 License 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 #** 8474386313

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: DONALD L. 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 7/1/06 to 6/30/07 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) _____	<u>10/29/07</u>
	(Type or Print Name) <u>GERTRUDE LA BARBERA</u>	(Date)
Paid Preparer	(Title) <u>EXECUTIVE DIRECTOR</u>	
	(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: 7/1/06 Ending: 6/30/07

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	<u>132</u>	Intermediate/DD	<u>132</u>	<u>48,180</u>	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>132</u>	TOTALS	<u>132</u>	<u>48,180</u>	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	<u>44,328</u>		<u>717</u>	<u>45,045</u>
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	<u>44,328</u>		<u>717</u>	<u>45,045</u>

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.49%

D. How many bed-hold days during this year were paid by the Department?

1,946 (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)

NONEF. 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: 6/30/07 Fiscal Year: 6/30/07

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

Facility Name & ID Number MOUNT ST JOSEPH # 0005520 Report Period Beginning: 7/1/06 Ending: 6/30/07

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 BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	104,900		6,090	110,990		110,990	(11,099)	99,891		1
2	Food Purchase		152,541		152,541		152,541	(15,254)	137,287		2
3	Housekeeping	253,842	16,247		270,089		270,089		270,089		3
4	Laundry	42,426	6,639		49,065		49,065		49,065		4
5	Heat and Other Utilities			218,853	218,853		218,853	(10,943)	207,910		5
6	Maintenance	199,955	43,705	320,044	563,704		563,704		563,704		6
7	Other (specify):*										7
8	TOTAL General Services	601,123	219,132	544,987	1,365,242		1,365,242	(37,296)	1,327,946		8
	B. Health Care and Programs										
9	Medical Director	29,400			29,400		29,400		29,400		9
10	Nursing and Medical Records	2,156,283	10,220	23,824	2,190,327	(19,350)	2,170,977		2,170,977		10
10a	Therapy	51,198			51,198	(6,857)	44,341		44,341		10a
11	Activities										11
12	Social Services	68,253		5,006	73,259		73,259		73,259		12
13	CNA Training					19,350	19,350		19,350		13
14	Program Transportation		21,875		21,875		21,875		21,875		14
15	Other (specify):* DAY TRAINING	227,547	24,613	118,113	370,273		370,273	(370,273)			15
16	TOTAL Health Care and Programs	2,532,681	56,708	146,943	2,736,332	(6,857)	2,729,475	(370,273)	2,359,202		16
	C. General Administration										
17	Administrative	108,000	6,039		114,039		114,039		114,039		17
18	Directors Fees										18
19	Professional Services			44,804	44,804		44,804		44,804		19
20	Dues, Fees, Subscriptions & Promotions			10,029	10,029		10,029		10,029		20
21	Clerical & General Office Expenses	202,895	22,287	6,648	231,830		231,830		231,830		21
22	Employee Benefits & Payroll Taxes			548,706	548,706		548,706	(14,653)	534,053		22
23	Inservice Training & Education										23
24	Travel and Seminar			395	395		395		395		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			88,179	88,179		88,179		88,179		26
27	Other (specify):*										27
28	TOTAL General Administration	310,895	28,326	698,761	1,037,982		1,037,982	(14,653)	1,023,329		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,444,699	304,166	1,390,691	5,139,556	(6,857)	5,132,699	(422,222)	4,710,477		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:

7/1/06

Ending:

6/30/07

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			366,918	366,918		366,918	30,442	397,360			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					6,857	6,857		6,857			35
36	Other (specify):*											36
37	TOTAL Ownership			546,918	546,918	6,857	553,775	(149,558)	404,217			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			346,600	346,600		346,600		346,600			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			346,600	346,600		346,600		346,600			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,444,699	304,166	2,284,209	6,033,074		6,033,074	(571,780)	5,461,294			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: 7/1/06

Ending: 6/30/07

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	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(26,353)	L 1&2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(50,567)	L 30		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				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals	(370,273)	L 15		23
24	Bad Debt	(14,653)	L 22		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				28
29	Other-Attach Schedule UTILITIES	(10,943)	L 5		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (472,789)		\$	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)	(98,991)	VII L 14	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (98,991)		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (571,780)		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: 7/1/06
 Ending: 6/30/07

Sch. V Line
 Reference

NON-ALLOWABLE EXPENSES		Amount	Reference	
1		\$		1
2				2
3				3
4	NON-PATIENT MEALS	(26,353)	L 1&2	4
5				5
6				6
7				7
8				8
9	NON-CARE DEPRECIATION	(50,567)	L 30	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	DAY TRAINING	(370,273)	L 15	23
24	DAY TRAINING PAYROLL TAXES	(14,653)	L 22	24
25				25
26				26
27				27
28				28
29	UTILITIES	(10,943)	L 5	29
30	SUBTOTAL (A):	(472,789)		30
31				31
32				32
33				33
34	ADJUSTMENTS FOR RELATED ORGANIZATI	-98,991	VII L 14	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	(571,780)		49

STATE OF ILLINOIS

Summary B

Facility Name & ID Number MOUNT ST JOSEPH

0005520

Report Period Beginning:

7/1/06

Ending:

6/30/07

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
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	(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	(98,990)	45								

Facility Name & ID Number MOUNT ST JOSEPH

0005520

Report Period Beginning:

7/1/06

Ending:

6/30/07

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: 7/1/06 Ending: 6/30/07

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: 7/1/06

Ending: 6/30/07

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									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 MOUNT ST JOSEPH # 0005520 Report Period Beginning: 7/1/06 Ending: 6/30/07

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.)

Facility Name & ID Number **MOUNT ST JOSEPH**

0005520 Report Period Beginning: **7/1/06**

Ending: **6/30/07**

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

B. Real Estate Taxes

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>																							
1. Real Estate Tax accrual used on 2006 report.		\$ N/A	1																				
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			2																				
3. Under or (over) accrual (line 2 minus line 1).		\$ #VALUE!	3																				
4. Real Estate Tax accrual used for 2007 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.		\$ TAX EXEMPT	7																				
<p>Real Estate Tax History:</p> <table border="1"> <tr> <td>Real Estate Tax Bill for Calendar Year:</td> <td>2002</td> <td>_____</td> <td>8</td> </tr> <tr> <td></td> <td>2003</td> <td>_____</td> <td>9</td> </tr> <tr> <td></td> <td>2004</td> <td>_____</td> <td>10</td> </tr> <tr> <td></td> <td>2005</td> <td>_____</td> <td>11</td> </tr> <tr> <td></td> <td>2006</td> <td>_____</td> <td>12</td> </tr> </table>				Real Estate Tax Bill for Calendar Year:	2002	_____	8		2003	_____	9		2004	_____	10		2005	_____	11		2006	_____	12
Real Estate Tax Bill for Calendar Year:	2002	_____	8																				
	2003	_____	9																				
	2004	_____	10																				
	2005	_____	11																				
	2006	_____	12																				
<table border="1"> <tr> <td></td> <td colspan="2">FOR BHF USE ONLY</td> <td></td> </tr> <tr> <td>13</td> <td>FROM R. E. TAX STATEMENT FOR 2006</td> <td>\$</td> <td>13</td> </tr> <tr> <td>14</td> <td>PLUS APPEAL COST FROM LINE 5</td> <td>\$</td> <td>14</td> </tr> <tr> <td>15</td> <td>LESS REFUND FROM LINE 6</td> <td>\$</td> <td>15</td> </tr> <tr> <td>16</td> <td>AMOUNT TO USE FOR RATE CALCULATION</td> <td>\$</td> <td>16</td> </tr> </table>					FOR BHF USE ONLY			13	FROM R. E. TAX STATEMENT FOR 2006	\$	13	14	PLUS APPEAL COST FROM LINE 5	\$	14	15	LESS REFUND FROM LINE 6	\$	15	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16
	FOR BHF USE ONLY																						
13	FROM R. E. TAX STATEMENT FOR 2006	\$	13																				
14	PLUS APPEAL COST FROM LINE 5	\$	14																				
15	LESS REFUND FROM LINE 6	\$	15																				
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16																				

NOTES:

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

2006 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME MOUNT ST JOSEPH COUNTY LAKE

FACILITY IDPH LICENSE NUMBER 0005520

CONTACT PERSON REGARDING THIS REPORT DON LASCO

TELEPHONE 847-438-5050 FAX #: 847-438-6313

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2006 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 2006.

(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 X 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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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:

7/1/06 Ending:

6/30/07

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</u>	<u>160 ACRES OR</u>	<u>1935</u>	<u>\$ 8,000</u>	1
2		<u>6,969,600 SQ. FEET</u>			2
3	TOTALS	#VALUE!		\$ 8,000	3

Facility Name & ID Number MOUNT ST JOSEPH

0005520

Report Period Beginning:

7/1/06

Ending:

6/30/07

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		1,377,602	6
7				1990	68,729	2,290	30	2,290		40,075	7
8											8
Improvement Type**											
9	LAND IMPROVEMENT-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	18,379		18,379		252,142	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						29
30				2003	250,123	259,208		259,208		1,659,709	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:

7/1/06

Ending:

6/30/07

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									42
43	ST. JOSEPH/REMODEL & PAINT	5-Jun	14,964						43
44	BARN/REMODEL,PAINT,& NEW ROOF	5-Aug	114,140						44
45	THERAPY/REMODEL & NEW CABINETS	5-Sep	20,421						45
46	THERAPY/PLUMBING	5-Sep	37,253						46
47	ADMINISTRATION/FILTER SYSTEM PLUMBING	5-Sep	32,500						47
48	MEDICAL/REMODEL & NEW CABINETS	5-Oct	28,259						48
49	DENTAL OFFICE/PLUMBING & COMPRESSOR	5-Nov	16,193						49
50	NURSES STATION/REMODEL & PAINT	5-Nov	21,140						50
51	FACILITY/NEW WINDOWS	5-Dec	116,318						51
52	VILLA/NEW FLOOR TILE	6-Jan	9,624						52
53	KITCHEN/ELECTRIC SERVICE	6-Feb	15,035						53
54	KITCHEN/REMODEL	6-Mar	5,802						54
55	KITCHEN/ELECTRIC WORK	6-Mar	88,000						55
56	ST. ROSE/FLOOR TILE	6-Jun	60,611						56
57	KITCHEN/ELECTRICAL SERVICE	6-Jun	41,500						57
58	THERAPY/NEW ENTRANCE	6-Jun	16,310						58
59	BARN/SIDING	6-Apr	38,585						59
60	FACILITY/STONE PIERS & WALL	6-Jun	67,785						60
61	SACRED HEART/REPAIRS & ROOF	6-Feb	69,957						61
62	NURSES STATION/NEW 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)		\$ 10,248,495	\$ 358,597		\$ 358,597	\$	\$ 8,336,537	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:

7/1/06

Ending:

6/30/07

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 12A, Carried Forward		\$ 10,248,495	\$ 358,597		\$ 358,597	\$	\$ 8,336,537	1
2	BUILDING IMPROVEMENTS								2
3									3
4	WALK-IN COOLER/KITCHEN	3-Sep	6,190						4
5	AIR CONDITIONER/NOVITIATE	3-Oct	105,000						5
6	AIR CONDITIONER/UNITS	3-Oct	1,800						6
7	FIRE ALARM/ANGEL GUARDIAN	3-Nov	4,800						7
8	SUBMERSIBLE PUMP	3-Nov	2,196						8
9	AIR COMPRESSOR	3-Dec	4,955						9
10	DRAIN,WATER CLOSET,SEWER/KITCHEN	3-Dec	12,567						10
11	CONDENSATE PUMP/ANGELINA	4-Jan	2,989						11
12	FIRE DOOR/SACRED HEART	4-Jan	3,448						12
13	NEW ROOF/GUANELLA HALL	4-Jan	36,237						13
14	AUTOMATIC DOOR/KITCHEN	4-Feb	8,032						14
15	2 COOLERS/KITCHEN	4-Mar	30,000						15
16	WALK-IN UNITS/KITCHEN	4-Mar	54,160						16
17	AUTOMATIC DOOR/THERAPY	4-Apr	6,736						17
18	GAS LINES/KITCHEN	4-Apr	3,708						18
19	AIR COMPRESSOR	4-May	1,809						19
20	AIR CONDITIONER/SACRED HEART	4-May	6,300						20
21	AIR CONDITIONER/ADMINISTRATION	4-May	12,290						21
22	HOT WATER LINES/MARCELLINA	4-Jun	4,273						22
23	COOLER WIRING/KITCHEN	4-Jun	1,890						23
24	TEST BALANCE/KITCHEN	4-Jun	18,820						24
25	AIR CONDITIONER/ADMINISTRATION	4-Jun	4,446						25
26	AIR CONDITIONER/KITCHEN	4-Apr	11,794						26
27	WALK-IN COOLER/KITCHEN	4-Jun	45,000						27
28	CONTROL VALVES/CRAWL SPACE	4-Jun	3,659						28
29	FREEZER COOLER WIRING/KITCHEN	4-Jun	9,000						29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,650,594	\$ 358,597		\$ 358,597	\$	\$ 8,336,537	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:

7/1/06

Ending:

6/30/07

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		\$ 10,650,594	\$ 358,597		\$ 358,597	\$	\$ 8,336,537	1
2	BUILDING IMPROVEMENTS								2
3									3
4	KITCHEN DRAIN LINE	4-Aug	3,901						4
5	CARPET/ADMINISTRATION	4-Aug	15,502						5
6	AIR CONDITIONER/ADMINISTRATION	4-Aug	5,112						6
7	INSPECT & CLEAN BOILERS	4-Sep	4,227						7
8	MOP SINK/ADMINISTRATION	4-Sep	3,630						8
9	ELECTRICAL/VILLA	4-Sep	16,000						9
10	REMODEL COOLER/KITCHEN	4-Sep	51,662						10
11	BOILER ROOM ROOF	4-Sep	23,741						11
12	ARCHITECTURAL SERVICE/KITCHEN	4-Sep	4,500						12
13	WALK-IN UNITS/KITCHEN	4-Sep	12,105						13
14	REPLACE SEWER PIPES/ST. MARY	4-Oct	15,740						14
15	GARAGE DOOR	4-Oct	4,312						15
16	EXHAUST FAN/ADMINISTRATION	4-Nov	2,945						16
17	WELL WATER PUMP	4-Nov	9,968						17
18	PERMIT FEE/KITCHEN	4-Dec	2,332						18
19	WATER COIL/ADMINISTRATION	4-Dec	7,940						19
20	REMODEL RECTORY BUILDING	4-Dec	18,588						20
21	REPAIR WATER MAIN	5-Jan	32,076						21
22	AIR COMPRESSOR	5-Jan	10,651						22
23	REPAIR GENERATOR	5-Feb	1,880						23
24	ELECTRICAL WORK/THERAPY	5-Feb	12,405						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	\$ 358,597		\$ 358,597	\$	\$ 8,336,537	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:

7/1/06

Ending:

6/30/07

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		\$ 10,909,811	\$ 358,597		\$ 358,597	\$	\$ 8,336,537	1
2	LAND IMPROVEMENT								2
3									3
4	TREE SERVICE	5-Mar	3,300						4
5	TREE SERVICE	5-Jun	2,400						5
6									6
7	BUILDING IMPROVEMENTS								7
8									8
9	ROOF HOUSE & GARAGE/PRIEST	5-Feb	19,714						9
10	LIGHT POLE/ADMINISTRATION	5-Feb	2,600						10
11	ELECTRICAL WORK/ADMINISTRATION	5-Mar	2,480						11
12	MASONRY & DRYWALL/ADMINISTRATION	5-Mar	29,840						12
13	LAMINATE CABINETS/KITCHEN	5-Mar	15,380						13
14	CABINETS/CHAPEL	5-Mar	2,800						14
15	HEAT EXCHANGER/ADMINISTRATION	5-Apr	7,000						15
16	SINK/KITCHEN	5-Apr	4,740						16
17	ROOF/THERAPY	5-May	10,859						17
18	DUMBWAITER/KITCHEN	5-Jun	2,464						18
19	REPAIRS & PAINT/ADMINISTRATION	5-Jun	14,433						19
20	WATER PIPE/ADMINISTRATION	5-Jun	9,334						20
21	ELECTRIC & SEPTIC/BARN	5-Jun	7,200						21
22	ROOF REPAIRS/ST. ALS	5-Jun	10,000						22
23	HEATING UNIT/KITCHEN	5-Jun	3,200						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	\$ 358,597		\$ 358,597	\$	\$ 8,336,537	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:

7/1/06

Ending:

6/30/07

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 12D, Carried Forward		\$ 11,057,555	\$ 358,597		\$ 358,597	\$	\$ 8,336,537	1
2	LAND IMPROVEMENTS								2
3	CHAINLINK FENCE	6-Oct	3,687						3
4	PAVEMENT REPAIR	7-Apr	33,000						4
5									5
6	BUILDING IMPROVEMENTS								6
7	ST. ROSE/REMODELLING	6-Jun	252,410						7
8	THERAPY/REMODELLING	7-Jan	203,276						8
9	CHAPEL/COMPRESSOR	6-Jun	11,294						9
10	PASSAGEWAY/REMODELLING	6-Oct	167,112						10
11	FIRE ALARM	6-Oct	20,140						11
12	ANGEL GUARDIAN/REMODELLING	6-Oct	30,087						12
13	FIRE ALARM MODULE/NUSRING	6-Oct	6,500						13
14	CONDENNSING UNIT/ROOF	6-Oct	3,800						14
15	KITCHEN/PUMP	6-Aug	5,400						15
16	TERRAZZO REPAIR/ST. ROSE	6-Nov	10,180						16
17	ST. AL/WATERPROOFING	6-Dec	7,695						17
18	DRY SYSTEM REPAIR	7-Jan	4,164						18
19	FIRE ALARM PANEL	7-Jan	16,900						19
20	ST. AL TUB INSTALLATION	7-Mar	34,983						20
21	ADMINISTRATION/PHONE SYSTEM	7-Mar	8,959						21
22	GYM/DRAPES	7-Apr	12,525						22
23	AIR COMPRESSOR SPRINKLER	7-Apr	4,924						23
24	ADMINISTRATION/TOILET PARTITIONS	7-Apr	7,800						24
25	TV ROOM CABINETS	7-Apr	17,900						25
26	ANGEL GUARDIAN/HOT WATER TANK	7-May	10,200						26
27	ABOVE GROUND POOL	7-Jun	20,565						27
28	ADMINISTRATION/REMODELLING	7-Jun	23,712						28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 11,974,768	\$ 358,597		\$ 358,597	\$	\$ 8,336,537	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:

7/1/06

Ending:

6/30/07

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 12E, Carried Forward	\$ 11,974,768	\$ 358,597		\$ 358,597	\$	\$ 8,336,537		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
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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)	\$ 11,974,768	\$ 358,597		\$ 358,597	\$	\$ 8,336,537		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: 7/1/06 Ending: 6/30/07

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	\$ 1,241,421	\$ 36,429	\$ 36,429	\$		\$ 1,167,963	71
72	Current Year Purchases	130,523						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,371,944	\$ 36,429	\$ 36,429	\$		\$ 1,167,963	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	\$ 14,004	76
77										77
78										78
79										79
80	TOTALS			\$ 23,334	\$ 2,334	\$ 2,334	\$		\$ 14,004	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)	\$ 13,378,046	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 397,360	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 397,360	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)	\$ 9,518,504	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	523,965	26,279	350,124	87
88	NON-CARE	1,052,810	24,288	947,490	88
89					89
90					90
91	TOTALS	\$ 1,617,091	\$ 50,567	\$ 1,337,930	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: 7/1/06

Ending: 6/30/07

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.	_____ /2008	\$ _____
13.	_____ /2009	\$ _____
14.	_____ /2010	\$ _____

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: \$ 6,857 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: 7/1/06 Ending: 6/30/07

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)	9,750	3,200		12,950
4	Clinical Wages (b)		6,400		6,400
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$ 9,750	\$ 9,600	\$	\$ 19,350
10	SUM OF line 9, col. 1 and 2 (e)	\$ 19,350			

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	8
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	7
2. From other facilities (f)	
TOTAL TRAINED	15

- (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	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	5 Units 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	29,400					29,400	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			\$ 29,400		\$	\$		\$ 29,400	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: 7/1/06

Ending:

6/30/07**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 6/30/07

(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	\$ 1,393,470	\$ 1,393,470	1
2	Cash-Patient Deposits	98,849	98,849	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,302,534	1,302,534	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	136,544	136,544	5
6	Prepaid Insurance	52,860	52,860	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,984,257	\$ 2,984,257	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	3,117,998	5,932,655	15
16	Equipment, at Historical Cost		3,034,980	16
17	Accumulated Depreciation (book methods)		(9,569,071)	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)	\$ 3,117,998	\$ 6,843,955	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,102,255	\$ 9,828,212	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 72,663	\$ 72,663	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	98,849	98,849	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	234,277	234,277	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 405,789	\$ 405,789	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 405,789	\$ 405,789	46
47	TOTAL EQUITY(page 18, line 24)	\$ 5,696,466	\$ 9,422,423	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,102,255	\$ 9,828,212	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 4,598,830	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 4,598,830	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,097,636	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)	\$ 1,097,636	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)	\$ 5,696,466	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number **MOUNT ST JOSEPH**

0005520

Report Period Beginning: **7/1/06**

Ending: **6/30/07**

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	\$ 5,873,478	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,873,478	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	37,800	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)	\$ 37,800	23
D. Non-Operating Revenue			
24	Contributions	626,481	24
25	Interest and Other Investment Income***	53,918	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 680,399	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	DEVELOPMENTAL DAY TRAINING	539,033	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 539,033	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,130,710	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,365,242	31
32	Health Care	2,729,475	32
33	General Administration	1,037,982	33
B. Capital Expense			
34	Ownership	553,775	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	346,600	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,033,074	40
41	Income before Income Taxes (line 30 minus line 40)**	1,097,636	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,097,636	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? YES 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: 7/1/06

Ending: 6/30/07

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	17,818	18,813	421,420	22.40
4	Licensed Practical Nurses	3,470	3,572	74,299	20.80
5	CNAs & Orderlies	2,850	2,902	24,663	8.50
6	CNA Trainees				6
7	Licensed Therapist				7
8	Rehab/Therapy Aides				8
9	Activity Director	2,223	2,283	38,124	16.70
10	Activity Assistants	1,132	1,189	13,074	11.00
11	Social Service Workers	3,480	3,585	68,253	19.04
12	Dietician				12
13	Food Service Supervisor				13
14	Head Cook	2,162	2,222	27,552	12.40
15	Cook Helpers/Assistants	7,700	7,735	77,348	10.00
16	Dishwashers				16
17	Maintenance Workers	12,428	12,498	199,955	16.00
18	Housekeepers	33,521	33,846	253,842	7.50
19	Laundry	4,644	4,714	42,426	9.00
20	Administrator	4,530	4,571	72,000	15.75
21	Assistant Administrator	3,100	3,130	36,000	11.50
22	Other Administrative				22
23	Office Manager				23
24	Clerical	20,090	20,290	202,895	10.00
25	Vocational Instruction				25
26	Academic Instruction				26
27	Medical Director	1,650	1,680	29,400	17.50
28	Qualified MR Prof. (QMRP)	8,163	8,189	139,203	17.00
29	Resident Services Coordinator				29
30	Habilitation Aides (DD Homes)	175,451	176,083	1,496,698	8.50
31	Medical Records				31
32	Other Health Care(specify)				32
33	Other(specify) <u>DAY TRAINING</u>	17,304	17,504	227,547	13.00
34	TOTAL (lines 1 - 33)	321,716	324,806	\$ 3,444,699 *	\$ 10.61

* 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	130	\$ 6,090	L1 C3
36	Medical Director			36
37	Medical Records Consultant	38	1,504	L10 C3
38	Nurse Consultant			38
39	Pharmacist Consultant			39
40	Physical Therapy Consultant	24	1,259	L10 C3
41	Occupational Therapy Consultant	25	1,463	L10 C3
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant			44
45	Social Service Consultant	156	11,698	L10 C3
46	Other(specify) <u>DENTIST</u>	134	6,685	L10 C3
47	<u>PSYCHIATRIST</u>	20	5,006	L12 C3
48	<u>PODIATRIST</u>	20	1,215	L10 C3
49	TOTAL (lines 35 - 48)	547	\$ 34,920	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: 7/1/06

Ending: 6/30/07

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	\$ 121,903	IDPH License Fee	\$ 200	
MARY WALKER	ADMINISTRATOR		36,000	Unemployment Compensation Insurance		Advertising: Employee Recruitment	3,800	
				FICA Taxes	252,276	Health Care Worker Background Check		
				Employee Health Insurance	81,941	(Indicate # of checks performed)		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*	92,586	LICENSE & FEES	2,413	
						DUES & SUBSCRIPTIONS	3,616	
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	395
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL			\$	
(Attach a copy of any management service agreement)								
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	\$ 27,300				\$	Out-of-State Travel	\$
AUTOMATIC DATA PROCESSING	PAYROLL	15,315						
CREMER, KOPON	LEGAL	2,189					In-State Travel	
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			\$	
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 44,804					

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number MOUNT ST JOSEPH

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. \$ 18,387 Line L 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 346,600
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. \$ 4,656
- 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, 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 \$5,000, 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.

V. COST CENTER EXPENSES RECLASSIFICATION PAGE 3
 FROM V. LINE 10 -19,350
 TO V. LINE 13 19,350
 TO RECLASSIFY NURSE AIDE TRAINING
 FROM V. LINE 10a -6,857
 TO V. LINE 35 6,857
 TO RECLASSIFY RENT-EQUIPMENT

V. COST CENTER EXPENSES OTHER LINE 15 PAGE 3
 DAY TRAINING SALARIES 227,547
 DAY TRAINING SUPPLIES 24,613
 DAY TRAINING BENEFITS 13,762
 DAY TRAINING OCCUPANCY 43,462
 DAY TRAINING TRANSPORT 53,123
 DAY TRAINING RENT 2,556
 DAY TRAINING DEPRECIATION 5,210 118,113
 SUBTOTAL 370,273
 DAY TRAINING P/R TAXES 14,653
 TOTAL 384,926

VI. ADJUSTMENT DETAIL PAGE 5
 NON-ALLOWABLE EXPENSES
 DIETARY V. LINE 1 110,990 X .10 = -11,099
 FOOD PURCHASE V. LINE 2 152,541 X .10 = -15,254 -26,353
 DEPRECIATION V. LINE 30 -50,567
 DAY TRAINING V. LINE 15 -370,273
 PAYROLL TAX D/T V. LINE 22 -14,653
 UTILITIES V. LINE 5 -10,943
 SUBTOTAL (A): -472,789
 RELATED ORGANIZATION VII. LINE 14 -98,991
 TOTAL ADJUSTMENTS -571,780

VI. ADJUSTMENT DETAIL SQUARE FOOTAGE PAGE 5
 CARE RELATED AREAS:
 THERAPEUTIC CENTER 29,450
 OLD NURSES STATION TO KITCHEN PASSAGEWAY 6,770
 ADMINISTRATIVE BUILDING 6,890
 NOVITIATE & AUDITORIUM 11,120
 ANGEL GUARDIAN 9,582
 BOILER & LAUNDRY 4,690
 CHAPEL 12,468
 GARAGE 1,012
 ST. MARY,S 11,691
 JOSEPH,S 9,464
 PASSAGEWAY 5,392
 ST. ALOYSIOUS 9,270
 GUANELLA 15,887
 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 AREAS 7,328/154,890 0.05
 TOTAL UTILITIES LINE 5 PAGE 3 218,853
 TOTAL NON-CARE RELATED AREAS: X .05 10,943

XVII. INCOME STATEMENT OTHER REVENUE PAGE 19
 DEVELOPMENTAL DAY TRAINING LINE 28a 539,033

XVIII. A. STAFFING & SALARY COSTS PAGE 20
 DAY TRAINING LINE 33 227,547

XX. GENERAL INFORMATION PAGE 23
 COST ASSOCIATED WITH SPACE RENTAL LINE 14 NUNS QUARTERS