

		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.

<p><b>I. IDPH License ID Number:</b> <u>0005637</u></p> <p><b>Facility Name:</b> <u>ST JOSEPH NURSING HOME</u></p> <p><b>Address:</b> <u>401 9TH STREET</u> <u>LACON</u> <u>61540</u>        Number City Zip Code</p> <p><b>County:</b> <u>MARSHALL</u></p> <p><b>Telephone Number:</b> <u>(309) 246-2175</u> <b>Fax #</b> <u>(309) 246-3609</u></p> <p><b>HFS ID Number:</b> <u>0005637</u></p> <p><b>Date of Initial License for Current Owners:</b> <u>1964</u></p> <p><b>Type of Ownership:</b></p> <table style="width:100%"> <tr> <td><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input checked="" type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td><b>IRS Exemption Code</b> <u>501(c)3</u></td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other <u>                    </u></td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td><input type="checkbox"/> Limited Liability Co. <u>                    </u></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other <u>                    </u></td> <td></td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>DWAYNE RICHARDSON</u> <b>Telephone Number:</b> <u>(314) 983-1225</u></p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	<b>IRS Exemption Code</b> <u>501(c)3</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other <u>                    </u>		<input type="checkbox"/> "Sub-S" Corp.	<input type="checkbox"/> Limited Liability Co. <u>                    </u>		<input type="checkbox"/> Trust			<input type="checkbox"/> Other <u>                    </u>		<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>7/01/2006</u> to <u>6/30/2007</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%"> <tr> <td rowspan="2" style="width:20%;"><b>Officer or Administrator of Provider</b></td> <td>(Signed) _____</td> </tr> <tr> <td>(Type or Print Name) <u>THOMAS E. BECHER</u> (Date) _____</td> </tr> <tr> <td></td> <td>(Title) <u>ADMINISTRATOR</u></td> </tr> <tr> <td rowspan="4"><b>Paid Preparer</b></td> <td>(Signed) _____</td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>PRINCIPAL</u></td> </tr> <tr> <td>(Firm Name &amp; Address) <u>BRWON SMITH WALLACE L.L.C.</u> <u>1050 N. LINDBERGH BLVD., ST. LOUIS, MO 63132</u></td> </tr> <tr> <td></td> <td>(Telephone) <u>(314) 983-1225</u> Fax # <u>(314) 983-1300</u></td> </tr> <tr> <td colspan="2">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</td> </tr> </table>	<b>Officer or Administrator of Provider</b>	(Signed) _____	(Type or Print Name) <u>THOMAS E. BECHER</u> (Date) _____		(Title) <u>ADMINISTRATOR</u>	<b>Paid Preparer</b>	(Signed) _____	(Date) _____	(Print Name and Title) <u>PRINCIPAL</u>	(Firm Name & Address) <u>BRWON SMITH WALLACE L.L.C.</u> <u>1050 N. LINDBERGH BLVD., ST. LOUIS, MO 63132</u>		(Telephone) <u>(314) 983-1225</u> Fax # <u>(314) 983-1300</u>	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	
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Facility Name & ID Number ST JOSEPH NURSING HOME

# 0005637 Report Period Beginning: 7/01/2006 Ending: 6/30/2007

**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	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 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	15,990	11,445	25	27,460
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	15,990	11,445	25	27,460

**C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.90%**

**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 \_\_\_\_\_ 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: 7/1/06-6/30/07 Fiscal Year: 7/1/06-6/30/07

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

Facility Name & ID Number **ST JOSEPH NURSING HOME** # **0005637** Report Period Beginning: **7/01/2006** Ending: **6/30/2007**

**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
	<b>A. General Services</b>										
1	Dietary	298,520		30,038	328,558		328,558	(35,105)	293,453		1
2	Food Purchase		199,105		199,105		199,105	(43,045)	156,060		2
3	Housekeeping	106,811	14,984		121,795		121,795		121,795		3
4	Laundry	81,200		7,370	88,570		88,570		88,570		4
5	Heat and Other Utilities			120,210	120,210		120,210	(4,444)	115,766		5
6	Maintenance	70,259		41,427	111,686		111,686		111,686		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	556,790	214,089	199,045	969,924		969,924	(82,594)	887,330		8
	<b>B. Health Care and Programs</b>										
9	Medical Director										9
10	Nursing and Medical Records	1,344,133	74,010	43,529	1,461,672		1,461,672		1,461,672		10
10a	Therapy	5,149			5,149		5,149		5,149		10a
11	Activities	67,911	7,388	17,108	92,407		92,407		92,407		11
12	Social Services	54,668	957	21,590	77,215		77,215		77,215		12
13	CNA Training			1,409	1,409		1,409		1,409		13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,471,861	82,355	83,636	1,637,852		1,637,852		1,637,852		16
	<b>C. General Administration</b>										
17	Administrative	91,068			91,068		91,068		91,068		17
18	Directors Fees										18
19	Professional Services			46,918	46,918		46,918		46,918		19
20	Dues, Fees, Subscriptions & Promotions			13,943	13,943		13,943	(835)	13,108		20
21	Clerical & General Office Expenses	112,045	12,200	51,087	175,332		175,332	(4,227)	171,105		21
22	Employee Benefits & Payroll Taxes			530,358	530,358		530,358	(7,580)	522,778		22
23	Inservice Training & Education										23
24	Travel and Seminar			7,697	7,697		7,697		7,697		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			37,036	37,036		37,036		37,036		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	203,113	12,200	687,039	902,352		902,352	(12,642)	889,710		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,231,764	308,644	969,720	3,510,127		3,510,127	(95,235)	3,414,892		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.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			54,064	54,064		54,064	(32,889)	21,175		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			183	183		183	(183)			32
33	Real Estate Taxes										33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles										35
36	Other (specify):*										36
37	<b>TOTAL Ownership</b>			54,247	54,247		54,247	(33,072)	21,175		37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers			12,053	12,053		12,053		12,053		39
40	Barber and Beauty Shops		581	11,816	12,397		12,397		12,397		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	<b>TOTAL Special Cost Centers</b>		581	74,787	75,368		75,368		75,368		44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,231,764	309,225	1,098,754	3,639,742		3,639,742	(128,307)	3,511,435		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:

7/01/2006

Ending:

6/30/2007

**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	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(19,497)	2		4
5	Telephone, TV & Radio in Resident Rooms	(4,227)	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	(31,520)	30		9
10	Interest and Other Investment Income	(183)	32		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	(2,274)	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	(835)	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 <u>SEE PAGE 5A FOR DETAILS</u>	(69,771)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (128,307)		\$	30

<b>BHF USE ONLY</b>					
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	
		<b>Amount</b>	<b>Reference</b>	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (128,307)		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
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>
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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$	47

ST JOSEPH NURSING HOME

ID# 0005637

Report Period Beginning: 7/01/2006

Ending: 6/30/2007

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Sisters' Portion of Dietary Costs	\$ (35,105)	1	1
2	Sisters' Portion of Food Costs	(21,274)	2	2
3	Sisters' Portion of Heat and Other Utilities	(4,444)	5	3
4	Sisters' Portion of Building Depreciation	(1,369)	30	4
5	Sisters' Portion of Employee Benefits in Meals	(7,580)	22	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
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40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(69,771)		49

ST. JOSEPH NURSING HOME  
PAGE 5A - NON-ALLOWABLE EXPENSES (RECLASSES AND ADJUSTMENTS) DETAIL  
Reporting Period Beginning JULY 1, 2006 and Ending JUNE 30, 2007

**Patient, Sister and Employee Meals:**

		Detail	Subtotals	Percentages
<b>Meals served to Patients:</b>	Patient Days (excl. bed-hold days)	27,460		
	Meals per day	3	82,380	89.32%
<b>Meals provided to Sisters (non-patient):</b>	Number of Sisters	9		
	Meals per day	3		
	Days per year	365	9,855	10.68%
<b>Total Meals Served</b>			<b>92,235</b>	<b>100.00%</b>

**Adjustments for Sisters' Maintenance:**

***Sisters' portion of dietary and***

***food cost:***

Dietary cost	\$ 328,558	<i>From page 3, Line 1, Col. 4</i>
Sisters' percentage	10.68%	<i>From calculation above</i>
<b>Sisters' Portion of Dietary Cost</b>	<b>\$ 35,105</b>	<b>Adjustment: To Line 1, Schedule V</b>

Food cost	\$ 199,105	<i>From page 3, Line 2, Col. 4</i>
Sisters' percentage	10.68%	<i>From calculation above</i>
<b>Sisters' Portion of Food Cost</b>	<b>\$ 21,274</b>	<b>Adjustment: To Line 2, Schedule V</b>

**Sisters' portion of building and utilities:**

***Sisters' portion of building:***

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%	

***Sisters' portion of utilities:***

Heat and Other Utilities	\$ 120,210	<i>From page 3, Line 5, Col. 4</i>
Sisters' percentage	3.70%	<i>From calculation above</i>
<b>Sisters' Portion of Heat and Other Utilities</b>	<b>\$ 4,444</b>	<b>Adjustment: To Line 5, Schedule V</b>

***Sisters' portion of building***

***depreciation expense:***

Building Depreciation Exp	\$ 37,025	<i>From G/L Account No. 782029-00</i>
Sisters' percentage	3.70%	<i>From calculation above</i>
<b>Sister's Portion of Building Depreciation</b>	<b>\$ 1,369</b>	<b>Adjustment: To Line 36, Schedule V (also see p 13 of CR)</b>

**Employee Benefits in Sisters' Meals:**

Dietary Salaries	\$ 298,520	<i>From page 3, Line 1, Col. 1</i>
Sisters' percentage	10.68%	<i>From calculation above</i>
<b>Salaries Applicable to Sister's Meals</b>	<b>\$ 31,896</b>	
Total Salaries	\$ 2,231,764	<i>From page 4, Line 45, Col. 1</i>
Employee Benefits	\$ 530,358	<i>From page 3, Line 22, Col. 4</i>
Employee benefits ratio	23.76%	
<b>Employee Benefits Applicable to Sisters' Meals</b>	<b>\$ 7,580</b>	<b>Adjustment: To Line 22, Schedule V</b>

**Total Adjustments for Sisters' Portion of Costs** **\$ 69,771**

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number ST JOSEPH NURSING HOME# 0005637

Report Period Beginning:

7/01/2006

Ending:

6/30/2007

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

	Operating Expenses	PAGES	PAGE	SUMMARY										
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
		(to Sch V, col.7)												
1	Dietary	(35,105)	0	0	0	0	0	0	0	0	0	0	(35,105)	1
2	Food Purchase	(43,045)	0	0	0	0	0	0	0	0	0	0	(43,045)	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	(4,444)	0	0	0	0	0	0	0	0	0	0	(4,444)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(82,594)</b>	<b>0</b>	<b>(82,594)</b>	<b>8</b>									
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	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	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(835)	0	0	0	0	0	0	0	0	0	0	(835)	20
21	Clerical & General Office Expenses	(4,227)	0	0	0	0	0	0	0	0	0	0	(4,227)	21
22	Employee Benefits & Payroll Taxes	(7,580)	0	0	0	0	0	0	0	0	0	0	(7,580)	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	<b>TOTAL General Administration</b>	<b>(12,642)</b>	<b>0</b>	<b>(12,642)</b>	<b>28</b>									
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(95,235)</b>	<b>0</b>	<b>(95,235)</b>	<b>29</b>									

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number ST JOSEPH NURSING HOME# 0005637

Report Period Beginning:

7/01/2006

Ending:

6/30/2007

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

	Capital Expense	PAGES	PAGE	SUMMARY										
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(32,889)	0	0	0	0	0	0	0	0	0	0	(32,889)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(183)	0	0	0	0	0	0	0	0	0	0	(183)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(33,072)</b>	<b>0</b>	<b>(33,072)</b>	<b>37</b>									
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(128,307)</b>	<b>0</b>	<b>(128,307)</b>	<b>45</b>									

Facility Name & ID Number

ST JOSEPH NURSING HOME

# 0005637

Report Period Beginning:

7/01/2006

Ending:

6/30/2007

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

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

Facility Name & ID Number **ST JOSEPH NURSING HOME** # **0005637** Report Period Beginning: **7/01/2006** Ending: **6/30/2007**

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	2	3	4	5	6		7		8	9
					Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1								\$		1
2	<b>THIS WORKSHEET IS NOT APPLICABLE.</b>									
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13							<b>TOTAL</b>	\$		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: **7/01/2006** Ending: **5/30/2007**

**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

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

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	<b>THIS WORKSHEET IS NOT APPLICABLE.</b>								
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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name &amp; ID Number

ST JOSEPH NURSING HOME

# 0005637

Report Period Beginning:

7/01/2006

Ending:

6/30/2007

## IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
	<b>A. Directly Facility Related</b>																	
	<b>Long-Term</b>																	
1	DAUGHTERS OF ST. FRANCIS OF						\$	\$			\$	1						
2	ASSISI (MOTHERHOUSE)	X		WORKING CAPITAL	VARIES	VARIOUS	224,000	37,000	NONE	NONE	NONE	2						
3	BANK OF LACON		X	WORKING CAPITAL	VARIES	8/11/2005	350,000	40,000	8/15/2008	9.9000	183	3						
4												4						
5												5						
	<b>Working Capital</b>																	
6												6						
7												7						
8												8						
9	<b>TOTAL Facility Related</b>						\$ 574,000	\$ 77,000			\$ 183	9						
	<b>B. Non-Facility Related*</b>																	
10												10						
11												11						
12												12						
13												13						
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14						
15	<b>TOTALS (line 9+line14)</b>						\$ 574,000	\$ 77,000			\$ 183	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**

**Important**, please see the next worksheet, "RE\_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2006 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 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.

\$                      **7**

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2002	<u>                    </u>	<b>8</b>
	2003	<u>                    </u>	<b>9</b>
	2004	<u>                    </u>	<b>10</b>
	2005	<u>                    </u>	<b>11</b>
	2006	<u>                    </u>	<b>12</b>

**FOR BHF USE ONLY**

<b>13</b>	FROM R. E. TAX STATEMENT FOR 2006	\$ <u>                    </u>	<b>13</b>
<b>14</b>	PLUS APPEAL COST FROM LINE 5	\$ <u>                    </u>	<b>14</b>
<b>15</b>	LESS REFUND FROM LINE 6	\$ <u>                    </u>	<b>15</b>
<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION	\$ <u>                    </u>	<b>16</b>

**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.**



Facility Name & ID Number ST JOSEPH NURSING HOME

# 0005637

Report Period Beginning:

7/01/2006 Ending:

6/30/2007

**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 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).

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	<b>TOTALS</b>	<b>428,532</b>		<b>\$ 25,700</b>	<b>3</b>

Facility Name &amp; ID Number ST JOSEPH NURSING HOME

# 0005637

Report Period Beginning:

7/01/2006

Ending:

6/30/2007

**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	
43			1965	\$ 484,023	\$	VARIOUS	\$	\$	\$ 484,023	4
50			1969	898,293		VARIOUS			898,293	5
			1968	451,401		25			451,401	6
			1986	3,877		12			3,877	7
			1987	5,840		15			5,840	8
<b>Improvement Type**</b>										
	MISC		1968	6,160		50			6,160	9
	GARAGE		1972	2,491		50			2,491	10
	FINISH BASEMENT		1973	6,343		50			6,343	11
	WINDOW		1974	900		50			900	12
	INSULATION		1976	21,986		50			21,986	13
	ROOF		1980	16,049		50			16,049	14
	MISC REMODELING		1981	7,711		10			7,711	15
	IDPA AUDIT ADJUSTMENTS		1982	1,290		10			1,290	16
	IDPA AUDIT ADJUSTMENTS		1983	877		10			877	17
	IDPA AUDIT ADJUSTMENTS		1984	53,742		VARIOUS			53,742	18
	IDPA AUDIT ADJUSTMENTS		1985	15,330		15			15,330	19
	IDPA AUDIT ADJUSTMENTS		1969	28,119		20			28,119	20
	IDPA AUDIT ADJUSTMENTS		1977	11,869	222	20	222		7,024	21
	IDPA AUDIT ADJUSTMENTS		1986	94,429		VARIOUS			94,429	22
	IDPA AUDIT ADJUSTMENTS		1989	146,038	4,100	VARIOUS	2,771	(1,329)	117,647	23
	DECORATING		1987	3,285		10			3,285	24
	PARKING LOT		1988	19,937		VARIOUS			19,937	25
	FIRE ALARM SYSTEM		1990	37,956	1,886	VARIOUS	1,886		33,727	26
	NEW ROOF		1992	55,787		10			55,787	27
	HOT WATER TANK		1992	3,295		10			3,295	28
	BUILDING PAINTING		1993	7,336		5			7,336	29
	ROOF REPAIRS		1993	434		10			434	30
	WATER HEATER		1993	223	15	15	15		217	31
	BOILER REPAIR		1993	1,415		10			1,415	32
	CODE ALERT FIRE SYSTEM		1995	8,559		10			8,559	33
	MISC		1997	3,013		10			3,013	34
	VINYL FLOOR		1998	4,012		5			4,012	35
										36

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

See Page 12A, Line 70 for total

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	CERAMIC FLOOR FOR NEW TUB	1999	\$ 107	\$ 5	20	\$ 5	\$	\$ 43	37
38	CARPET ON WALLS	2000	2,668		5			2,668	38
39	METAMORA TELEPHONE SYSTEM	2000	7,337	734	10	734		5,505	39
40	TOMKAT ROOFING	2001	18,760	1,876	10	1,876		12,194	40
41	HOBERT CORP	2001	1,555	156	10	156		1,014	41
42	ASPHALT REPAIR	2002	2,900	363	8	363		1,996	42
43									43
44	75 GALLON 365M ASME WTR HTR	2006	5,225	523	10	523		784	44
45	ULTRA CARE 709 BED LAMINATE PANELS	2006	5,809	387	15	387		580	45
46	HOYER PROF PATIENT LIFT	2006	3,020	302	10	302		453	46
47	HOYER PROF VERTICAL PATIENT LIFT W/ SCALE	2006	4,249	424	10	424		636	47
48									48
49	CONCRETE SIDEWALK	2007	5,220	174	15	174		174	49
50	ROOFING	2007	20,986	1,049	10	1,049		1,049	50
51	FIRE DAMPERS	2007	13,100	437	15	437		437	51
52	BEDS (16)	2007	19,904	664	15	664		664	52
53	DOOR ALARM SYSTEM	2007	20,963	699	15	699		699	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)		\$ 2,533,823	\$ 14,016		\$ 12,687	\$ (1,329)	\$ 2,393,355	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:

7/01/2006

Ending:

6/30/2007

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	\$ 40,048	\$ 9,857	\$ (30,191)		\$ 113,506	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	465,884					465,884	73
74								74
75	TOTALS	\$ 624,537	\$ 40,048	\$ 9,857	\$ (30,191)		\$ 579,390	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					19,135	79
80	TOTALS			\$ 49,690	\$	\$	\$		\$ 49,690	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)	\$ 3,233,750	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 54,064	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 22,544	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (31,520)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,022,435	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	<b>TOTAL</b>				\$			7

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	<b>TOTAL</b>		\$	\$	21

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 \$ \_\_\_\_\_

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

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

**XIII. EXPENSES RELATING TO 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>50</u></p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</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		311		311
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)		1,098		1,098
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	<b>TOTALS</b>	\$	\$ 1,409	\$	\$ 1,409
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$	1,409		

**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	6
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	<b>6</b>

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	4					
					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		visits		<b>THIS WORKSHEET IS NOT APPLICABLE.</b>					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	<b>TOTAL</b>			\$		\$	\$		\$	14

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

Facility Name &amp; ID Number ST JOSEPH NURSING HOME

# 0005637

Report Period Beginning: 7/01/2006

Ending:

6/30/2007

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/2007

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 1,052,561	\$	1
2	Cash-Patient Deposits	1,757		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance NONE )	229,173		3
4	Supply Inventory (priced at COST )	35,579		4
5	Short-Term Investments			5
6	Prepaid Insurance	1,935		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 1,321,005	\$	10
	<b>B. Long-Term Assets</b>			
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	248,088		15
16	Equipment, at Historical Cost	1,318,598		16
17	Accumulated Depreciation (book methods)	(2,692,899)		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	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 495,165	\$	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 1,816,170	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 46,624	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	166,589		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>BANK LINE OF CREDIT</u>	40,000		36
37	<u>DEFERRED REVENUE</u>	52,700		37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 305,913	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>DUE TO MOTHERHOUSE</u>	37,000		43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 37,000	\$	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 342,913	\$	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 1,473,257	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 1,816,170	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>1,870,581</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>1,870,581</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(397,324)	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ (397,324)	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>1,473,257</b>	<b>24</b> *

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

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

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

1

	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 4,422,297	1
2	Discounts and Allowances for all Levels	(1,313,028)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 3,109,269	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	586	12
13	Barber and Beauty Care	21,627	13
14	Non-Patient Meals	19,497	14
15	Telephone, Television and Radio	4,227	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	9,694	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 55,631	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions	13,446	24
25	Interest and Other Investment Income***	37,950	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 51,396	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>SISTERS' MAINTENANCE</u>	26,122	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 26,122	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 3,242,418	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	969,924	31
32	Health Care	1,637,852	32
33	General Administration	902,352	33
	<b>B. Capital Expense</b>		
34	Ownership	54,247	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	24,450	35
36	Provider Participation Fee	50,918	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 3,639,742	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(397,324)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (397,324)	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 **ST JOSEPH NURSING HOME**

# **0005637**

Report Period Beginning:

**7/01/2006**

Ending:

**6/30/2007**

**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	2,089	2,281	\$ 66,134	\$ 28.99	1
2	Assistant Director of Nursing	1,134	1,182	24,417	20.66	2
3	Registered Nurses	8,420	9,195	168,931	18.37	3
4	Licensed Practical Nurses	12,386	13,631	237,675	17.44	4
5	CNAs & Orderlies	62,624	68,777	676,023	9.83	5
6	CNA Trainees	2,233	2,465	20,762	8.42	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,632	1,843	33,915	18.40	8
9	Activity Director	2,009	2,281	28,617	12.55	9
10	Activity Assistants	5,240	5,570	42,794	7.68	10
11	Social Service Workers	4,201	4,536	58,276	12.85	11
12	Dietician					12
13	Food Service Supervisor	2,039	2,263	43,548	19.24	13
14	Head Cook	6,091	6,640	59,551	8.97	14
15	Cook Helpers/Assistants	10,660	11,402	84,764	7.43	15
16	Dishwashers	12,592	14,143	120,401	8.51	16
17	Maintenance Workers	4,088	4,601	76,750	16.68	17
18	Housekeepers	12,144	13,429	108,481	8.08	18
19	Laundry	6,133	6,866	74,075	10.79	19
20	Administrator	2,109	2,281	97,111	42.57	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,089	2,281	34,760	15.24	23
24	Clerical	6,071	6,786	86,958	12.81	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	1,850	2,066	21,897	10.60	31
32	Other Health C: (MDS Coordinator)	3,118	3,370	65,924	19.56	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	170,952	187,889	\$ 2,231,764 *	\$ 11.88	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	124	\$ 2,995	1.3	35
36	Medical Director				36
37	Medical Records Consultant	48	1,735	10.3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	169	1,100	10.3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	9	346	10.3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	32	2,048	10.3	43
44	Activity Consultant	21	1,268	11.3	44
45	Social Service Consultant	29	1,718	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	432	\$ 11,210		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	\$ 91,068	Workers' Compensation Insurance	\$ 60,165	IDPH License Fee	\$	
				Unemployment Compensation Insurance	18,773	Advertising: Employee Recruitment	6,782	
				FICA Taxes	160,583	Health Care Worker Background Check (Indicate # of checks performed _____)		
				Employee Health Insurance	276,672	<b>Background Checks</b>		
				Employee Meals				
				Illinois Municipal Retirement Fund (IMRF)*		<b>Dues and licenses</b>	7,161	
				Other Employee Benefits	14,165			
				Less Sisters Maintenance Adjustment	(7,580)			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 91,068					
B. Administrative - Other								
Description			Amount					
			\$					
TOTAL (agree to Schedule V, line 17, col. 3) (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
Enloe Drugs, Inc	Pharmaceuticals		\$ 13,697	This schedule is not applicable.		\$	Out-of-State Travel	\$ NONE
Mayer Hoffman McCann	Audit Services		8,800					
CBIZ Valuation Group	Accounting Services		6,175					
OSF Medical Group	Insurance Services		5,200				In-State Travel	1,381
Catholic Mutual Group	Insurance Services		3,750					
Alliance Benefit Group	Benefits Consulting		2,385				Vehicle Maintenance and Gas	2,378
Kronos Inc	Payroll Software		2,098					
Dr. Melvin Kaplan	Dental Services		1,824				Seminar Expense	3,938
PK Bhosale ALA	Supplies		1,120					
MSW Projects	Computer Services		675					
Red Wing Software	Network Support		539					
Others (less than \$500 each)	Various		655				Entertainment Expense	( )
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 46,918	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ 7,697

\* Attach copy of IMRF notifications

\*\*See instructions.

**ST. JOSEPH NURSING HOME**  
**SCHEDULE XIX C. - SUPPORT SCHEDULES - PROFESSIONAL SERVICES**  
**Reporting Period Beginning JULY 1, 2006 and Ending JUNE 30, 2007**

<u>Vendor / Payee</u>		<u>Amount</u>
Enloe Drugs, Inc	\$	13,697
Mayer Hoffman McCann		8,800
CBIZ Valuation Group		6,175
OSF Medical Group		5,200
Catholic Mutual Group		3,750
Alliance Benefit Group		2,385
Kronos Inc		2,098
Dr. Melvin Kaplan		1,824
PK Bhosale ALA		1,120
MSW Projects		675
Red Wing Software		539
Accu-Med Services		200
Fidelity on Call		176
Heyl Royster Voelker		129
Junior Talley		125
Matt's PC		25
<b>Total</b>	\$	<b>46,918</b>

**ST. JOSEPH NURSING HOME**  
**SCHEDULE XIX G. - SUPPORT SCHEDULES - SEMINAR EXPENSE**  
**Reporting Period Beginning JULY 1, 2006 and Ending JUNE 30, 2007**

<u>Seminar Name</u>	<u>Employee(s)</u>	<u>Date</u>	<u>Cost</u>
Illinois Nursing Home Admin Assoc.	Thomas Becher	7/31/2006 \$	95
Southern Illinois University CNA Class	Judy Kissee	10/20/2006	300
Life Safety Seminar	Thomas Becher/Richard DuBois	10/28/2006	290
American Red Cross	Joan Quigg	11/21/2006	916
American Red Cross	Joan Quigg	11/30/2006	111
LSN Foundation	Sandy Colwell/Lori Maxedon	1/11/2007	297
Urinary Incontinence Program	Sandy Colwell	2/7/2007	125
Illinois Nursing Home Admin Assoc.	Sandy Colwell/Thomas Becher	2/28/2007	95
Illinois Nursing Home Admin Assoc.	Thomas Becher	2/28/2007	95
Land of Lincoln College	Judy Kissee	3/6/2007	80
Illinois Department on Aging	Michele Spicer	3/13/2007	25
Get Motivated Seminar	Becher/DuBois, Spicer/Hagemeier	3/29/2007	78
Life Services Network	Thomas Becher/Sandy Colwell	4/28/2007	594
Illinois Dementia Care	Beclcher, Poe, Stear, Duncalf	6/5/2007	375
Life Services Network	Thomas Becher	6/13/2007	115
Life Services Network	Sandy Colwell/Lori Maxedon	7/28/2007	297
Diocese of Peoria-Health Care Day	Thomas Becher	10/26/2007	50
	<b>TOTAL</b>	<b>\$</b>	<b><u><u>3,938</u></u></b>



Facility Name & ID Number ST JOSEPH NURSING HOME# 0005637Report Period Beginning: 7/01/2006Ending: 6/30/2007**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 Association, AAHSA, Life Services Network, Lacon Chamber of Commerce
- (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? 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? 13.26
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 36,993 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? YES  
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 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-ADJUSTMENTS 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. \$ 0 Has any meal income been offset against related costs? YES Indicate the amount. \$ 19,497
- (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? 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? 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: Brown Smith Wallace LLC 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
- (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