

Facility Name & ID Number MOUNT ST JOSEPH

0005520 Report Period Beginning: 07/01/07 Ending: 6/30/08

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment			
		Medicaid Recipient	Private Pay	Other	
8	SNF				8
9	SNF/PED				9
10	ICF				10
11	ICF/DD	40,059		668	40,727
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	40,059		668	40,727

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.53%

D. How many bed-hold days during this year were paid by the Department? 1,224 (Do not include bed-hold days in Section B.)

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

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

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

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

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

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

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

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 6/30/08 Fiscal Year: 6/30/08

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

Facility Name & ID Number MOUNT ST JOSEPH # 0005520 Report Period Beginning: 07/01/07 Ending: 6/30/08

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	118,664		7,556	126,220		126,220	(12,622)	113,598		1
2	Food Purchase		143,992		143,992		143,992	(14,399)	129,593		2
3	Housekeeping	252,520	16,461		268,981		268,981		268,981		3
4	Laundry	45,837	3,910		49,747		49,747		49,747		4
5	Heat and Other Utilities			250,259	250,259		250,259	(12,513)	237,746		5
6	Maintenance	223,061	45,443	249,973	518,477		518,477		518,477		6
7	Other (specify):*										7
8	TOTAL General Services	640,082	209,806	507,788	1,357,676		1,357,676	(39,534)	1,318,142		8
	B. Health Care and Programs										
9	Medical Director	24,860			24,860		24,860		24,860		9
10	Nursing and Medical Records	2,067,593	7,533	20,371	2,095,497	(20,530)	2,074,967		2,074,967		10
10a	Therapy	20,606			20,606	(10,508)	10,098		10,098		10a
11	Activities										11
12	Social Services	66,774		4,729	71,503		71,503		71,503		12
13	CNA Training					20,530	20,530		20,530		13
14	Program Transportation		34,976		34,976		34,976		34,976		14
15	Other (specify):* DAY TRAINING	242,819	19,579	124,374	386,772		386,772	(386,772)			15
16	TOTAL Health Care and Programs	2,422,652	62,088	149,474	2,634,214	(10,508)	2,623,706	(386,772)	2,236,934		16
	C. General Administration										
17	Administrative	108,000	14,200		122,200		122,200		122,200		17
18	Directors Fees										18
19	Professional Services			53,646	53,646		53,646		53,646		19
20	Dues, Fees, Subscriptions & Promotions			17,690	17,690		17,690		17,690		20
21	Clerical & General Office Expenses	194,343	22,348	5,165	221,856		221,856		221,856		21
22	Employee Benefits & Payroll Taxes			507,017	507,017		507,017	(15,822)	491,195		22
23	Inservice Training & Education										23
24	Travel and Seminar			65	65		65		65		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			75,048	75,048		75,048		75,048		26
27	Other (specify):*										27
28	TOTAL General Administration	302,343	36,548	658,631	997,522		997,522	(15,822)	981,700		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,365,077	308,442	1,315,893	4,989,412	(10,508)	4,978,904	(442,128)	4,536,776		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:

07/01/07

Ending:

6/30/08

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			379,933	379,933		379,933	27,192	407,125			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					10,508	10,508		10,508			35
36	Other (specify):*											36
37	TOTAL Ownership			559,933	559,933	10,508	570,441	(152,808)	417,633			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			337,724	337,724		337,724		337,724			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			337,724	337,724		337,724		337,724			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,365,077	308,442	2,213,550	5,887,069		5,887,069	(594,936)	5,292,133			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: 07/01/07

Ending: 6/30/08

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	(27,021)	LI&2		3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(53,817)	L30		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	(386,772)	L15		23
24	Bad Debt	(15,822)	L22		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule UTILITIES	(12,513)	L5		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (495,945)		\$	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)			34
35	Other- Attach Schedule	(98,991)	L14	35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (98,991)		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (594,936)		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						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: 07/01/07
 Ending: 6/30/08

Sch. V Line Reference

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1		\$		1
2				2
3	NON-PATIENT MEALS	(27,021)	L 1 & 2	3
4				4
5				5
6				6
7				7
8				8
9	NON-CARE DEPRECIATION	(53,817)	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	(386,772)	L 15	23
24	DAY TRAINING PAYROLL TAXES	(15,822)	L 22	24
25				25
26				26
27				27
28				28
29	UTILITIES	(12,513)	L 5	29
30	SUBTOTAL (A) :	(495,945)		30
31				31
32				32
33				33
34	COST SCHEDULE VII	-98991	VII L 14	34
35				35
36	SUBTOTAL (B) :	-98991		36
37	TOTAL ADJUSTMENTS (A) AND (B)	-594936		37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(1,784,808)		49

STATE OF ILLINOIS

Summary B

Facility Name & ID Number MOUNT ST JOSEPH

0005520

Report Period Beginning:

07/01/07

Ending:

6/30/08

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	81,009	0	0	0	0	0	0	0	0	0	81,009	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	(98,991)	0	(98,991)	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	(98,991)	0	(98,991)	45								

Facility Name & ID Number MOUNT ST JOSEPH

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Report Period Beginning:

07/01/07

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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	81,009	DAUGHTERS OF ST. MARY OF PROVIDENCE	100.00%		81,009	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		\$ (98,991)			\$	\$ * (98,991)	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:

07/01/07

Ending:

6/30/08

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.			84	100.00	SALARY	\$ 72,000	L 17 C 1	1
2	SR. MARY WALKER	ADMINISTRATOR	DIRECTOR			84	100.00	SALARY	36,000	L 17 C 1	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: 07/01/07

Ending: 6/30/08

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	N/A				\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number MOUNT ST JOSEPH # 0005520 Report Period Beginning: 07/01/07 Ending: 6/30/08

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.)

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 2007 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).		\$ TAX EXEMPT	3																				
4. Real Estate Tax accrual used for 2008 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>2003</td> <td>_____</td> <td>8</td> </tr> <tr> <td></td> <td>2004</td> <td>_____</td> <td>9</td> </tr> <tr> <td></td> <td>2005</td> <td>_____</td> <td>10</td> </tr> <tr> <td></td> <td>2006</td> <td>_____</td> <td>11</td> </tr> <tr> <td></td> <td>2007</td> <td>_____</td> <td>12</td> </tr> </table>				Real Estate Tax Bill for Calendar Year:	2003	_____	8		2004	_____	9		2005	_____	10		2006	_____	11		2007	_____	12
Real Estate Tax Bill for Calendar Year:	2003	_____	8																				
	2004	_____	9																				
	2005	_____	10																				
	2006	_____	11																				
	2007	_____	12																				
<table border="1"> <tr> <td colspan="4">FOR BHF USE ONLY</td> </tr> <tr> <td>13</td> <td>FROM R. E. TAX STATEMENT FOR 2007</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 2007	\$	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 2007	\$	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:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

2007 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME MOUNT ST JOSEPH COUNTY LAKE

FACILITY IDPH LICENSE NUMBER 0005520

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE (____) _____ FAX #: (____) _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2007 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 2007.

(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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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:

07/01/07 Ending:

6/30/08

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:

07/01/07

Ending:

6/30/08

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		1,456,322	6
7				1990	68,729	2,290	30	2,290		42,365	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	15,310		15,310		267,452	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						30
31				2004	402,099	280,077		280,077		1,939,786	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:

07/01/07

Ending:

6/30/08

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

1	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								37
38	7-Oct	3,687						38
39	7-Apr	33,000						39
40								40
41								41
42	6-Aug	252,410						42
43	7-Jan	203,276						43
44	6-Sep	11,294						44
45	6-Oct	167,112						45
46	6-Oct	20,140						46
47	6-Oct	30,087						47
48	6-Oct	6,500						48
49	6-Oct	3,800						49
50	6-Aug	5,400						50
51	6-Nov	10,180						51
52	6-Dec	7,695						52
53	7-Jan	4,164						53
54	7-Jan	16,900						54
55	7-Mar	34,983						55
56	7-Mar	8,959						56
57	7-Apr	12,525						57
58	7-Apr	4,924						58
59	7-Apr	7,800						59
60	7-Apr	17,900						60
61	7-May	10,200						61
62	7-Jun	20,565						62
63	7-Jun	23,712						63
64								64
65								65
66								66
67								67
68								68
69								69
70		\$ 10,651,692	\$ 376,397		\$ 376,397	\$	\$ 8,712,934	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:

07/01/07

Ending:

6/30/08

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		\$ 10,651,692	\$ 376,397		\$ 376,397	\$	\$ 8,712,934	1
2									2
3	LAND IMPROVEMENTS:								3
4	LANDSCAPING	5-Aug	17,048						4
5	LANDSCAPING & PLANTS	6-Jun	9,230						5
6									6
7	BUILDING IMPROVEMENTS:								7
8	ST. JOSEPH-REMODEL & PAINT	5-Jul	14,964						8
9	BARN-REMODEL,PAINT,NEW ROOF	5-Aug	114,140						9
10	THERAPY-REMODEL & NEW CABINETS	5-Sep	20,421						10
11	THERAPY-PLUMBING	5-Sep	37,253						11
12	ADMINISTRATION-FILTER SYSTEM PLUMBING	5-Sep	32,500						12
13	MEDICAL RECORDS-REMODEL & NEW CABINETS	5-Oct	28,259						13
14	DENTAL OFFICE-PLUMBING & COMPRESSOR	5-Nov	16,193						14
15	NURSES STATION-REMODEL & PAINT	5-Nov	21,140						15
16	FACILITY-NEW WINDOWS	5-Dec	116,318						16
17	VILLA-NEW FLOOR TILE	6-Jan	9,624						17
18	KITCHEN-ELECTRIC SERVICE	6-Feb	15,035						18
19	KITCHEN-REMODEL & PAINT	6-Mar	5,802						19
20	KITCHEN-ELECTRIC WORK	6-Mar	88,000						20
21	ST.ROSE-REPLACE FLOOR TILE	6-Jun	60,611						21
22	KITCHEN-ELECTRIC SERVICE	6-Jun	41,500						22
23	THERAPY-NEW ENTRANCE	6-Jun	16,310						23
24	BARN-SIDING	6-Apr	38,585						24
25	FACILITY-STONE PIERS & WALL	6-Jun	67,785						25
26	SACRED HEART-REPAIRS & ROOF	6-Feb	69,957						26
27	NURSES STATION-NEW ROOF	6-Feb	19,760						27
28	NURSES STATION-FIRE ALARM	6-Feb	12,280						28
29	CHAPEL-NEW ROOF	6-Jun	37,000						29
30	THERAPY-VINYL FLOOR	6-Feb	6,400						30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 11,567,807	\$ 376,397		\$ 376,397	\$	\$ 8,712,934	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:

07/01/07

Ending:

6/30/08

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		\$ 11,567,807	\$ 376,397		\$ 376,397	\$	\$ 8,712,934	1
2	LAND IMPROVEMENT:								2
3	TREE SERVICE	5-Mar	3,300						3
4		5-Jun	2,400						4
5	BUILDING IMPROVEMENTS:								5
6	PRIEST HOUSE-HOUSE & GARAGE ROOF	5-Feb	19,714						6
7	ADMINISTRATION-LIGHT POLE	5-Feb	2,600						7
8	ADMINISTRATION-ELECTRICAL WORK	5-Mar	2,480						8
9	ADMINISTRATION-MASONRY & DRY WALL	5-Mar	29,840						9
10	KITCHEN-LAMINATE CABINETS	5-Mar	15,380						10
11	CHAPEL-CABINETS	5-Mar	2,800						11
12	ADMINISTRATION-HEAT EXCHANGER	5-Apr	7,000						12
13	KITCHEN-SINK	5-Apr	4,740						13
14	THERAPY-ROOF	5-May	10,859						14
15	KITCHEN-DUMB WAITER	5-Jun	2,464						15
16	ADMINISTRATION-REPAIRS & PAINT	5-Jun	14,433						16
17	ADMINISTRATION=WATER PIPE	5-Jun	9,334						17
18	BARN-ELECTRIC & SEPTIC	5-Jun	7,200						18
19	ST. AL,S-ROOF REPAIR	5-Jun	10,000						19
20	KITCHEN-HEATING UNIT	5-Jun	3,200						20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 11,715,551	\$ 376,397		\$ 376,397	\$	\$ 8,712,934	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:

07/01/07

Ending:

6/30/08

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		\$ 11,715,551	\$ 376,397		\$ 376,397	\$	\$ 8,712,934	1
2	BUILDING IMPROVRMENTS:								2
3	KITCHEN-DRAIN LINE	4-Aug	3,901						3
4	ADMINISTRATION-CARPET	4-Aug	15,502						4
5	ADMINISTRATION-AIR CONDITIONER	4-Aug	5,112						5
6	ADMINISTRATION-CLEAN & INSPECT BOILERS	4-Sep	4,227						6
7	ADMINISTRATION-INSTALL MOP SINK	4-Sep	3,630						7
8	VILLA-ELECTRICAL WORK	4-Sep	16,000						8
9	KITCHEN-REMODEL COOLER	4-Sep	51,662						9
10	BOILER ROOM-ROOF	4-Sep	23,741						10
11	KITCHEN-ARCHITECTURAL SERVICE	4-Sep	4,500						11
12	KITCHEN-WALK IN UNITS	4-Sep	12,105						12
13	ST. MARY-REPLACE SEWER PIPE	4-Oct	15,740						13
14	GARAGE-REPLACE DOOR	4-Oct	4,312						14
15	ADMINISTRATION-EXHAUST FAN	4-Nov	2,945						15
16	WELL WATER PUMP	4-Nov	9,968						16
17	KITCHEN-PERMIT FEE	4-Dec	2,332						17
18	ADMINISTRATION-WATER COIL	4-Dec	7,940						18
19	RECTORY-REPAIR BUILDING	4-Dec	18,588						19
20	REPAIR WATER MAIN	5-Jan	32,076						20
21	AIR COMPRESSOR	5-Jan	10,651						21
22	REPAIR GENERATOR	5-Feb	1,880						22
23	THERAPY-ELECTRICAL WORK	5-Feb	12,405						23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 11,974,768	\$ 376,397		\$ 376,397	\$	\$ 8,712,934	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:

07/01/07

Ending:

6/30/08

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		\$ 11,974,768	\$ 376,397		\$ 376,397	\$	\$ 8,712,934	1
2	BUILDING IMPROVEMENTS:								2
3	ADMINISTRATION-REPLACE DRAIN PIPE	7-Jul	80,260						3
4	NEW BUILDING-ELECTRICAL	7-Jul	28,523						4
5	THERAPY-SKYLIGHTS	7-Jul	6,500						5
6	POOL-NEW DECK	7-Aug	22,974						6
7	THERAPY-RR7 AIR SPA	7-Sep	31,858						7
8	ADMINISTRATION-NEW PHONE SYSTEM	7-Sep	26,239						8
9	THERAPY-REST ROOM TILE,PLUMBING	7-Oct	94,209						9
10	ADMINISTRATION-RELOCATE GAS MAIN	7-Oct	3,559						10
11	ST. MARY,S-HEAT CONTROL	7-Nov	3,638						11
12	STORAGE TANK-PIPING	7-Nov	18,408						12
13	THERAPY-2 TUBS & LIFTS	7-Nov	4,070						13
14	THERAPY-TUB ROOM CABINETS	7-Dec	13,400						14
15	THERAPY-R47 AIR SPA SYSTEM	8-Jan	117,087						15
16	KITCHEN-SPRINKLER	8-Jan	12,500						16
17	ADMINISTRATION-FIRE PROTECTION TANK	8-Jan	30,470						17
18	KITCHEN-OVEN HOOD	8-Feb	11,233						18
19	ADMINISTRATION-UNDERGROUND SPRINKLER	8-Feb	6,298						19
20	ADMINISTRATION-2 MAN HOLE COVERS	8-Feb	7,700						20
21	NEW BUILDING-TILE,PAINT,WALLPAPER	8-Feb	8,856						21
22	ADMINISTRATION-REST ROOM TILE,PLUMBING	8-Mar	60,935						22
23	ADMINISTRATION-CLEANED BOILERS	8-Mar	3,194						23
24	ADMINISTRATION-REROUTE WATER LINE	8-Mar	5,325						24
25	THERAPY-CAT WALK 2 HR RATED DOORS	8-Mar	2,691						25
26	KITCHEN-KETTLE & OVEN	8-Mar	36,527						26
27	NEW BUILDING-FLOORING,WINDOWS,,PAINT	8-Mar	150,000						27
28	KITCHEN-4 STAINLESS STEEL TANKS	8-Apr	2,824						28
29	PUMPHOUSE-RELOCATE POWER	8-Apr	10,458						29
30	KITCHEN-CHILLED WATER PUMP REPAIR	8-Apr	2,075						30
31	KITCHEN-MOVE GAS METER	8-Apr	6,215						31
32	ATTIC-ALUMINUM DOOR	8-Apr	2,372						32
33	LIVINGROOM-2 CHANDLIERS	8-Apr	2,024						33
34	TOTAL (lines 1 thru 33)		\$ 12,787,190	\$ 376,397		\$ 376,397	\$	\$ 8,712,934	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:

07/01/07

Ending:

6/30/08

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 12F, Carried Forward		\$ 12,787,190	\$ 376,397		\$ 376,397	\$	\$ 8,712,934	1
2	BUILDING IMPROVEMENTS:								2
3	WATER MAIN-GLASS INSULLATION	8-Apr	4,334						3
4	ADMINISTRATION-SEWER REPAIR	8-Apr	16,225						4
5	KITCHEN-SURFACE TOPS	8-Apr	51,967						5
6	GYM-CONDENSATE TANK	8-Apr	5,381						6
7	NEW BUILDING-32 COPPER LIGHTS	8-Apr	4,370						7
8	KITCHEN-OVEN HOOD REPLACEMENT	8-Apr	11,233						8
9	THERAPY-200 GAL WATER TANK	8-Apr	5,134						9
10	NEW BUILDING-PLUMBING & ELECTRICAL	8-Apr	151,389						10
11	THERAPY-REPLACE HOT WATER HEATER	8-May	17,529						11
12	KITCHEN-TILE WORK	8-May	50,940						12
13	KITCHEN-HOOD REPLACEMENT	8-May	11,574						13
14	KITCHEN-REMOVE HALLWAY WINDOW	8-May	2,500						14
15	KITCHEN-ACCOUSTIC WALL COVERING	8-May	9,800						15
16	GYM-CONCRETE STOOP	8-Jun	9,503						16
17	KITCHEN-SEPTIC TANK	8-Jun	13,090						17
18	NEW BUILDING-FLOOR COVERINGS	8-Jun	180,000						18
19	BOILERS-DRAIN & FLUSH	8-Jun	3,526						19
20	KITCHEN-REROUTE RADIATORSUPPLY	8-Jun	5,321						20
21	THERAPY-WINDOW CAULKING	8-Jun	4,100						21
22	NEW BUILDING-PLUMBING & ELECTRICAL	8-Jun	398,823						22
23									23
24	LAND IMPROVEMENT:								24
25	TREE REMOVAL	7-Dec	2,000						25
26	CHAIN LINK FENCE	8-May	47,454						26
27	LANDSCAPING	8-Jun	23,887						27
28	PAVING	8-Jun	59,000						28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 13,876,270	\$ 376,397		\$ 376,397	\$	\$ 8,712,934	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: 07/01/07 Ending: 6/30/08

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	\$ 1,371,944	\$ 28,394	\$ 28,394	\$		\$ 28,394	71
72	Current Year Purchases	19,119						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,391,063	\$ 28,394	\$ 28,394	\$		\$ 1,196,357	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	\$ 16,338	76
77										77
78										78
79										79
80	TOTALS			\$ 23,334	\$ 2,334	\$ 2,334	\$		\$ 16,338	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)	\$ 15,298,667	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 407,125	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 407,125	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)	\$ 9,925,629	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	571,919	30,642	380,766	87
88	NON-CARE	1,052,810	23,175	970,665	88
89					89
90					90
91	TOTALS	\$ 1,665,045	\$ 53,817	\$ 1,391,747	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: 07/01/07

Ending: 6/30/08

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.	_____ /2009	\$ _____
13.	_____ /2010	\$ _____
14.	_____ /2011	\$ _____

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: \$ 10,508 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: 07/01/07 Ending: 6/30/08

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)	130	6,800		6,930
4	Clinical Wages (b)		13,600		13,600
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$ 130	\$ 20,400	\$	\$ 20,530
10	SUM OF line 9, col. 1 and 2 (e)	\$ 20,530			

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	17
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	4
2. From other facilities (f)	
TOTAL TRAINED	21

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care	9/1	visits	24,860					24,860	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	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$ 24,860		\$	\$		\$ 24,860	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: 07/01/07

Ending:

6/30/08**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 6/30/08

(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	\$ 1,099,839	\$ 1,099,839	1
2	Cash-Patient Deposits	77,879	77,879	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,316,078	1,316,078	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	143,072	143,072	5
6	Prepaid Insurance	50,790	50,790	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)	\$ 2,687,658	\$ 2,687,658	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	5,199,496	7,853,276	15
16	Equipment, at Historical Cost		3,079,442	16
17	Accumulated Depreciation (book methods)		(9,979,446)	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)	\$ 5,199,496	\$ 8,398,663	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 7,887,154	\$ 11,086,321	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 585,962	\$ 585,962	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	77,879	77,879	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	235,274	235,274	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)	\$ 899,115	\$ 899,115	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)	\$ 899,115	\$ 899,115	46
47	TOTAL EQUITY(page 18, line 24)	\$ 6,988,039	\$ 10,187,206	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 7,887,154	\$ 11,086,321	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 5,696,466	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 5,696,466	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,291,573	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)	\$ 1,291,573	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)	\$ 6,988,039	24 *

* This must agree with page 17, line 47.

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

0005520

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

Ending: **6/30/08**

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	\$ 5,965,676	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,965,676	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		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)	\$	23
D. Non-Operating Revenue			
24	Contributions	614,812	24
25	Interest and Other Investment Income***	51,078	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 665,890	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	DEVELOPMENTAL DAY TRAINING	547,076	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 547,076	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,178,642	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,357,676	31
32	Health Care	2,623,706	32
33	General Administration	997,522	33
B. Capital Expense			
34	Ownership	570,441	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	337,724	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,887,069	40
41	Income before Income Taxes (line 30 minus line 40)**	1,291,573	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,291,573	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: 07/01/07

Ending:

6/30/08

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	16,905	17,908	401,137	22.40	3
4	Licensed Practical Nurses	2,950	3,068	63,823	20.80	4
5	CNAs & Orderlies	2,503	2,553	21,701	8.50	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,280	1,340	22,376	16.70	9
10	Activity Assistants					10
11	Social Service Workers	1,450	1,555	29,604	19.04	11
12	Dietician					12
13	Food Service Supervisor	3,001	3,064	36,770	12.00	13
14	Head Cook	1,610	1,690	20,952	12.40	14
15	Cook Helpers/Assistants	6,054	6,094	60,941	10.00	15
16	Dishwashers					16
17	Maintenance Workers	13,901	13,941	223,061	16.00	17
18	Housekeepers	34,675	34,986	262,395	7.50	18
19	Laundry	3,684	3,724	33,513	9.00	19
20	Administrator	4,525	4,571	72,000	15.75	20
21	Assistant Administrator	3,102	3,130	36,000	11.50	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	19,230	19,434	194,343	10.00	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director	1,411	1,421	24,860	17.50	27
28	Qualified MR Prof. (QMRP)	7,982	8,011	136,190	17.00	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	173,401	174,423	1,482,592	8.50	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>DAY TRAINING</u>	18,402	18,678	242,819	13.00	33
34	TOTAL (lines 1 - 33)	316,066	319,591	\$ 3,365,077 *	\$ 10.53	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	151	\$ 7,556	L 1 C 3	35
36	Medical Director				36
37	Medical Records Consultant	19	752	L 10 C 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	41	2,243	L 10 C 3	40
41	Occupational Therapy Consultant	6	390	L 10 C 3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	174	11,845	L 10 C 3	45
46	Other(specify) <u>DENTIST</u>	80	4,001	L 10 C 3	46
47	<u>PSYCHIATRIST</u>	20	4,729	L 12 C 3	47
48	<u>PODIATRIST</u>	19	1,140	L 10 C 3	48
49	TOTAL (lines 35 - 48)	510	\$ 32,656		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

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? 10 YEARS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 22,305 Line L10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 337,724
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. \$ 2,255
- c. What percent of all travel expense relates to transportation of nurses and patients? NO
- 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: BIK & 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	-20,530
TO V. LINE 13	20,530
TO RECLASSIFY NURSE AIDE TRAINING	
FROM V. LINE 10a	-10,508
TO V. LINE 35	10,508
TO RECLASSIFY RENT-EQUIPMENT	

V. COST CENTER EXPENSES OTHER LINE 15 PAGE 3

DAY TRAINING SALARIES	242,819
DAY TRAINING SUPPLIES	19,579
DAY TRAINING BENEFITS	8,855
DAY TRAINING OCCUPANCY	51,577
DAY TRAINING TRANSPORT	55,991
DAY TRAINING RENT	2,556
DAY TRAINING DEPRECIATION	5,395 124,374
DAY TRAINING SUB-TOTAL	386,772
DAY TRAINING P/R TAXES	15,822
TOTAL	402,594

VI. ADJUSTMENT DETAIL PAGE 5

NON-ALLOWABLE EXPENSES

DIETARY V. LINE 1 126,220 X .10 =	-12,622
FOOD PURCHASE V. LINE 2 143,992 X .10	-14,399 -27,021
DEPRECIATION V. LINE 30	-53,817
DAY TRAINING V. LINE 15	-386,772
DAY TRAINING P/R TAX V. LINE 22	-15,822
UTILITIES V. LINE 5	-12,513
SUBTOTAL (A):	-495,945
RELATED PARTIES VII. LINE 14	-98,936
TOTAL ADJUSTMENTS A AND B	-594,936

VI. ADJUSTMENT DETAIL/UTILITIES PAGE 5 SQUARE FOOTAGE

CARE RELATED AREAS:	
THERAPY CENTER	29,450
NURSES STATION TO 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. ALOYIUS	9,270
GUANELLA	15,987
KITCHEN	5,749
GARAGE	660
CHAPLAIN,S HOUSE	4,022
ADMINISTRATIVE BLDG. 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 = 5

TOTAL UTILITIES LINE 5 PAGE 3	250,259X
TOTAL NON-CARE RELATED UTILITIES	0.05 -12,513

XVII. INCOME STATEMENT OTHER REVENUE PAGE 19

DEVELOPMENTAL DAY TRAINING LINE 28a	547,076
DEVELOPMENTAL DAY TRAINING LINE 33	242,819

XX. GENERAL INFORMATION PAGE 23

COST ASSOCIATED WITH SPACE RENTAL LINE 23 NUN QUARTERS