

Facility Name & ID Number ST JOSEPH NURSING HOME

0005637 Report Period Beginning: 7/1/2007 Ending: 6/30/2008

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)	93	33,945	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7		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	Total	
8	SNF					8
9	SNF/PED					9
10	ICF	15,096	9,094	29	24,219	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,096	9,094	29	24,219	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 71.35%

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 _____ and days of care provided _____

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRAU MODIFIED CASH* CASH*

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

Tax Year: 7/1/07 - 6/30/2008 Fiscal Year: 7/1/07 - 6/30/2008

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

Facility Name & ID Number **ST JOSEPH NURSING HOME** # **0005637** Report Period Beginning: **7/1/2007** Ending: **6/30/2008**

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
1	A. General Services										
1	Dietary	322,530		11,888	334,418		334,418	(39,942)	294,476		1
2	Food Purchase		224,353		224,353		224,353	(61,048)	163,305		2
3	Housekeeping	113,820	17,259		131,079		131,079		131,079		3
4	Laundry	99,753		7,790	107,543		107,543		107,543		4
5	Heat and Other Utilities			144,700	144,700		144,700	(5,349)	139,351		5
6	Maintenance	74,365		34,568	108,933		108,933		108,933		6
7	Other (specify):*										7
8	TOTAL General Services	610,468	241,612	198,946	1,051,026		1,051,026	(106,339)	944,687		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	1,230,829	79,210	57,906	1,367,945		1,367,945		1,367,945		10
10a	Therapy	66,604			66,604		66,604		66,604		10a
11	Activities	74,921	3,879	7,407	86,207		86,207		86,207		11
12	Social Services	62,972	834	3,040	66,846		66,846		66,846		12
13	CNA Training			1,122	1,122		1,122		1,122		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,435,326	83,923	69,475	1,588,724		1,588,724		1,588,724		16
	C. General Administration										
17	Administrative	54,502			54,502		54,502		54,502		17
18	Directors Fees										18
19	Professional Services			172,836	172,836		172,836		172,836		19
20	Dues, Fees, Subscriptions & Promotions			32,753	32,753		32,753	(2,181)	30,572		20
21	Clerical & General Office Expenses	109,821	9,986	54,267	174,074		174,074	(3,418)	170,656		21
22	Employee Benefits & Payroll Taxes			501,560	501,560		501,560	(8,742)	492,818		22
23	Inservice Training & Education										23
24	Travel and Seminar			9,239	9,239		9,239		9,239		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			25,015	25,015		25,015		25,015		26
27	Other (specify):*										27
28	TOTAL General Administration	164,323	9,986	795,670	969,979		969,979	(14,341)	955,638		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,210,117	335,521	1,064,091	3,609,729		3,609,729	(120,680)	3,489,049		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 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			52,185	52,185		52,185	(31,856)	20,329		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			9,586	9,586		9,586	(9,586)			32
33	Real Estate Taxes										33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles										35
36	Other (specify):*										36
37	TOTAL Ownership			61,771	61,771		61,771	(41,442)	20,329		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers			17,899	17,899		17,899		17,899		39
40	Barber and Beauty Shops		215	9,711	9,926		9,926		9,926		40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			51,670	51,670		51,670		51,670		42
43	Other (specify):*										43
44	TOTAL Special Cost Centers		215	79,280	79,495		79,495		79,495		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,210,117	335,736	1,205,142	3,750,995		3,750,995	(162,122)	3,588,873		45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	1	2	3	
NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1 Day Care	\$		\$	1
2 Other Care for Outpatients				2
3 Governmental Sponsored Special Programs				3
4 Non-Patient Meals	(12,087)	2		4
5 Telephone, TV & Radio in Resident Rooms	(3,418)	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	(30,545)	30		9
10 Interest and Other Investment Income	(9,586)	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	(22,165)	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 Income Taxes and Illinois Personal Property Replacement Tax	(2,181)	20		25
26 CNA Training for Non-Employees				26
27 Yellow Page Advertising				27
28 Other-Attach Schedule	(82,140)			28
29 Other-Attach Schedule				29
30 SUBTOTAL (A): (Sum of lines 1-29)	\$ (162,122)		\$	30

BHF USE ONLY						
48		49		50		51
						52

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

	1	2	
	Amount	Reference	
31 Non-Paid Workers-Attach Schedule*	\$		31
32 Donated Goods-Attach Schedule*			32
33 Amortization of Organization & Pre-Operating Expense			33
34 Adjustments for Related Organization Costs (Schedule VII)			34
35 Other- Attach Schedule			35
36 SUBTOTAL (B): (sum of lines 31-35)	\$		36
(sum of SUBTOTALS			
37 TOTAL ADJUSTMENTS (A) and (B))	\$ (162,122)		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

ST JOSEPH NURSING HOME

ID# 0005637

Report Period Beginning: 7/1/2007

Ending: 6/30/2008

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Sisters' Portion of Dietary Costs	\$ (39,942)	1	1
2	Sisters' Portion of Food Costs	(26,796)	2	2
3	Sisters' Portion of Heat and Other Utilities	(5,349)	5	3
4	Sisters' Portion of Building Depreciation	(1,311)	30	4
5	Sisters' Portion of Employee Benefits in Meals	(8,742)	22	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(82,140)		49

ST. JOSEPH NURSING HOME
PAGE 5A - NON-ALLOWABLE EXPENSES (RECLASSES AND ADJUSTMENTS) DETAIL
Reporting Period Beginning JULY 1, 2007 and Ending JUNE 30, 2008

Patient, Sister and Employee Meals:

		Detail	Subtotals	Percentages
<i>Meals served to Patients:</i>	Patient Days	24,219		
	Meals per day	3	72,657	88.06%
<i>Meals provided to Sisters (non-patient):</i>	Number of Sisters	9		
	Meals per day	3		
	Days per year	365	9,855	11.94%
Total Meals Served			82,512	100.00%

Adjustments for Sisters' Maintenance:

Sisters' portion of dietary and food cost:

Dietary cost	\$ 334,418	<i>From page 3, Line 1, Col. 4</i>
Sisters' percentage	11.94%	<i>From calculation above</i>
Sisters' Portion of Dietary Cost	\$ 39,942	Adjustment: To Line 1, Schedule V
Food cost	\$ 224,353	<i>From page 3, Line 2, Col. 4</i>
Sisters' percentage	11.94%	<i>From calculation above</i>
Sisters' Portion of Food Cost	\$ 26,796	Adjustment: To Line 2, Schedule V

Sisters' portion of building and utilities:

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

Sisters' portion of utilities:

Heat and Other Utilities	\$ 144,700	<i>From page 3, Line 5, Col. 4</i>
Sisters' percentage	3.70%	<i>From calculation above</i>
Sisters' Portion of Heat and Other Utilities	\$ 5,349	Adjustment: To Line 5, Schedule V

Sisters' portion of building depreciation expense:

Building Depreciation Exp	\$ 35,457	<i>From G/L Account No. 782029-00</i>
Sisters' percentage	3.70%	<i>From calculation above</i>
Sister's Portion of Building Depreciation	\$ 1,311	Adjustment: To Line 36, Schedule V (also see p 13 of CR)

Employee Benefits in Sisters' Meals:

Dietary Salaries	\$ 322,530	<i>From page 3, Line 1, Col. 1</i>
Sisters' percentage	11.94%	<i>From calculation above</i>
Salaries Applicable to Sister's Meals	\$ 38,522	
Total Salaries	\$ 2,210,117	<i>From page 4, Line 45, Col. 1</i>
Employee Benefits	\$ 501,560	<i>From page 3, Line 22, Col. 4</i>
Employee benefits ratio	22.69%	
Employee Benefits Applicable to Sisters' Meals	\$ 8,742	Adjustment: To Line 22, Schedule V

Total Adjustments for Sisters' Portion of Costs **\$ 82,140**

STATE OF ILLINOIS

Summary A

Facility Name & ID Number ST JOSEPH NURSING HOME# 0005637

Report Period Beginning:

7/1/2007

Ending:

6/30/2008

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(39,942)	0	0	0	0	0	0	0	0	0	0	(39,942)	1
2	Food Purchase	(61,048)	0	0	0	0	0	0	0	0	0	0	(61,048)	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	(5,349)	0	0	0	0	0	0	0	0	0	0	(5,349)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(106,339)	0	0	0	0	0	0	0	0	0	0	(106,339)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(2,181)	0	0	0	0	0	0	0	0	0	0	(2,181)	20
21	Clerical & General Office Expenses	(3,418)	0	0	0	0	0	0	0	0	0	0	(3,418)	21
22	Employee Benefits & Payroll Taxes	(8,742)	0	0	0	0	0	0	0	0	0	0	(8,742)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(14,341)	0	0	0	0	0	0	0	0	0	0	(14,341)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(120,680)	0	0	0	0	0	0	0	0	0	0	(120,680)	29

STATE OF ILLINOIS

Facility Name & ID Number ST JOSEPH NURSING HOME# 0005637

Report Period Beginning:

7/1/2007

Ending:

Summary B

6/30/2008

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)
	D. Ownership												
30	Depreciation	(31,856)	0	0	0	0	0	0	0	0	0	0	(31,856) 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	(9,586)	0	0	0	0	0	0	0	0	0	0	(9,586) 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	TOTAL Ownership	(41,442)	0	0	0	0	0	0	0	0	0	0	(41,442) 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)	(162,122)	0	0	0	0	0	0	0	0	0	0	(162,122) 45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
THIS WORKSHEET IS NOT APPLICABLE.						

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

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

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

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

Facility Name & ID Number ST JOSEPH NURSING HOME # 0005637 Report Period Beginning: 7/1/2007 Ending: 6/30/2008

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

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

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

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

0005637

Report Period Beginning:

7/1/2007

Ending: **7/30/2008**

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$			1
2	THIS WORKSHEET IS NOT APPLICABLE.								
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

ST JOSEPH NURSING HOME

0005637

Report Period Beginning:

7/1/2007

Ending:

6/30/2008

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	DAUGHTERS OF ST. FRANCIS OF						\$	\$			\$	1								
2	ASSISI (MOTHERHOUSE)	X		WORKING CAPITAL	VARIES	VARIOUS	224,000	37,000	NONE	NONE		2								
3	BANK OF LACON		X	WORKING CAPITAL	VARIES	8/11/2005	350,000	40,000	8/15/2008	9.9000		3								
4												4								
5												5								
	Working Capital																			
6												6								
7												7								
8												8								
9	TOTAL Facility Related						\$ 574,000	\$ 77,000			\$	9								
	B. Non-Facility Related*																			
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 574,000	\$ 77,000			\$	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

		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 2007 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 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.			\$	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2003	_____	8	
		2004	_____	9	
		2005	_____	10	
		2006	_____	11	
		2007	_____	12	
THIS WORKSHEET IS NOT APPLICABLE.					
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 ST JOSEPH NURSING HOME COUNTY MARSHALL

FACILITY IDPH LICENSE NUMBER 0005637

CONTACT PERSON REGARDING THIS REPORT DWAYNE RICHARDSON

TELEPHONE (314) 983 - 1200 FAX #: (314) 983 - 1300

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.	<u>THIS WORKSHEET IS NOT APPLICABLE.</u>	\$ _____	\$ _____
3.		\$ _____	\$ _____
4.		\$ _____	\$ _____
5.		\$ _____	\$ _____
6.		\$ _____	\$ _____
7.		\$ _____	\$ _____
8.		\$ _____	\$ _____
9.		\$ _____	\$ _____
10.		\$ _____	\$ _____
TOTALS		\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 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.

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	TOTALS	428,532		\$ 25,700	3

Facility Name & ID Number ST JOSEPH NURSING HOME

0005637

Report Period Beginning:

7/1/2007

Ending:

6/30/2008

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	43			1965	\$ 484,023		VARIOUS			\$ 484,023	4
5	50			1969	898,293		VARIOUS			898,293	5
6				1968	451,401		25			451,401	6
7				1986	3,877		12			3,877	7
8				1987	5,840		15			5,840	8
	Improvement Type**										
9	MISC			1968	6,160		50			6,160	9
10	GARAGE			1972	2,491		50			2,491	10
11	FINISH BASEMENT			1973	6,343		50			6,343	11
12	WINDOW			1974	900		50			900	12
13	INSULATION			1976	21,986		50			21,986	13
14	ROOF			1980	16,049		50			16,049	14
15	MISC REMODELING			1981	7,711		10			7,711	15
16	IDPA AUDIT ADJUSTMENTS			1982	1,290		10			1,290	16
17	IDPA AUDIT ADJUSTMENTS			1983	877		10			877	17
18	IDPA AUDIT ADJUSTMENTS			1984	53,742		VARIOUS			53,742	18
19	IDPA AUDIT ADJUSTMENTS			1985	15,330		15			15,330	19
20	IDPA AUDIT ADJUSTMENTS			1969	28,119	222	20	222		28,119	20
21	IDPA AUDIT ADJUSTMENTS			1977	11,869		20			7,246	21
22	IDPA AUDIT ADJUSTMENTS			1986	94,429	4,100	VARIOUS	2,771	(1,329)	94,429	22
23	IDPA AUDIT ADJUSTMENTS			1989	146,038		VARIOUS			120,418	23
24	DECORATING			1987	3,285		10			3,285	24
25	PARKING LOT			1988	19,937	1,886	VARIOUS	1,886		19,937	25
26	FIRE ALARM SYSTEM			1990	37,956		VARIOUS			35,613	26
27	NEW ROOF			1992	55,787		10			55,787	27
28	HOT WATER TANK			1992	3,295		10			3,295	28
29	BUILDING PAINTING			1993	7,336		5			7,336	29
30	ROOF REPAIRS			1993	434	6	10	6		434	30
31	WATER HEATER			1993	223		15			223	31
32	BOILER REPAIR			1993	1,415		10			1,415	32
33	CODE ALERT FIRE SYSTEM			1995	8,559		10			8,559	33
34	MISC			1997	3,013		10			3,013	34
35	VINYL FLOOR			1998	4,012		5			4,012	35
36											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	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38	CERAMIC FLOOR FOR NEW TUB	1999	107	5	20	5		48	38
39	CARPET ON WALLS	2000	2,668		5			2,668	39
40	METAMORA TELEPHONE SYSTEM	2000	7,337	734	10	734		6,239	40
41	TOMKAT ROOFING	2001	18,760	1,876	10	1,876		14,070	41
42	HOBERT CORP	2001	1,555	156	10	156		1,170	42
43	ASPHALT REPAIR	2002	2,900	363	8	363		2,359	43
44									44
45	75 GALLON 365M ASME WTR HTR	2006	5,225	523	10	523		1,307	45
46	ULTRA CARE 709 BED LAMINATE PANELS	2006	5,809	387	15	387		967	46
47	HOYER PROF PATIENT LIFT	2006	3,020	302	10	302		755	47
48	HOYER PROF VERTICAL PATIENT LIFT W/ SCALE	2006	4,249	424	10	424		1,060	48
49									49
50	CONCRETE SIDEWALK	2007	5,220	348	15	348		522	50
51	ROOFING	2007	20,986	2,098	10	2,098		3,147	51
52	FIRE DAMPERS	2007	13,100	874	15	874		1,311	52
53	BEDS (16)	2007	19,904	1,328	15	1,328		1,992	53
54	DOOR ALARM SYSTEM	2007	20,963	1,398	15	1,398		2,097	54
55	FURNITURE & EQUIPMENT - NURSING SERVICE	2008	21,360	785	15	785		785	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)		\$ 2,555,183	\$ 17,815		\$ 16,486	\$ (1,329)	\$ 2,409,841	70

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

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	\$ 34,370	\$ 5,154	\$ (29,216)		\$ 118,660	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	465,884					465,884	73
74								74
75	TOTALS	\$ 624,537	\$ 34,370	\$ 5,154	\$ (29,216)		\$ 584,544	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 USE	CHEVY CAPRICE	1987	\$ 10,289	\$	\$	\$		\$ 10,289	76
77	NURSING HOME USE	PICK-UP	1995	14,590					14,590	77
78	NURSING HOME USE	MISC. OTHER	VARIOUS	5,676					5,676	78
79	NURSING HOME USE	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)	\$ 3,255,110	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 52,185	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 21,640	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (30,545)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,044,075	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	SISTERS' SHARE OF BUILDING	\$ 63,491	\$	\$ 63,491	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 63,491	\$	\$ 63,491	91

G. Construction-in-Progress

	Description	Cost	
92			92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____ **THIS WORKSHEET IS NOT APPLICABLE.**
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. YES NO

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

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.
9. Option to Buy: YES NO Terms: _____*

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? YES NO
16. Rental Amount for movable equipment: \$ _____ Description: _____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:
Beginning _____
Ending _____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	<u>2009</u>	\$ _____
13.	<u>2010</u>	\$ _____
14.	<u>2011</u>	\$ _____

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

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input 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. CLASSROOM PORTION:</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>80</u></p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA <u>40</u></p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

	Facility			Total
	1 Drop-outs	2 Completed	3 Contract	
1 Community College Tuition	\$	\$	\$	\$
2 Books and Supplies		750		750
3 Classroom Wages (a)				
4 Clinical Wages (b)				
5 In-House Trainer Wages (c)		1,170		1,170
6 Transportation				
7 Contractual Payments		300		300
8 CNA Competency Tests				
9 TOTALS	\$	\$ 2,220	\$	\$ 2,220
10 SUM OF line 9, col. 1 and 2 (e)	\$	2,220		

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

C. CONTRACTUAL INCOME

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

\$ NONE

D. NUMBER OF CNAs TRAINED

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5	6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Staff		Outside Practitioner (other than consultant)								
			Units 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		visits										5
6	Dental Care		visits		THIS WORKSHEET IS NOT APPLICABLE.								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	Other (specify):												12
13	Other (specify):												13
14	TOTAL			\$		\$		\$				\$	14

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

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **6/30/2008** (last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 343,064	\$	1
2	Cash-Patient Deposits	1,857		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance NONE)	301,633		3
4	Supply Inventory (priced at COST)	35,781		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	1,936		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 684,271	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	79,003		13
14	Buildings, at Historical Cost	1,542,375		14
15	Leasehold Improvements, at Historical Cost	248,137		15
16	Equipment, at Historical Cost	1,322,835		16
17	Accumulated Depreciation (book methods)	(2,745,084)		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)	\$ 447,266	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,131,537	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 101,251	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	177,420		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	Bank Line of Credit	155,000		36
37	Deferred Revenue	15,686		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 449,357	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	Due to Motherhouse	26,000		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 26,000	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 475,357	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ #REF!	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ #REF!	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ #REF!	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ #REF!	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(817,077)	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)	\$ (817,077)	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)	\$ #REF!	24 *

* 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	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,014,354	1
2	Discounts and Allowances for all Levels	(1,210,735)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,803,619	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	307	12
13	Barber and Beauty Care	13,027	13
14	Non-Patient Meals	12,087	14
15	Telephone, Television and Radio	3,418	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	22,165	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 51,004	23
D. Non-Operating Revenue			
24	Contributions	33,538	24
25	Interest and Other Investment Income***	24,915	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 58,453	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Sisters' Maintenance	20,842	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 20,842	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,933,918	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,051,026	31
32	Health Care	1,588,724	32
33	General Administration	969,979	33
B. Capital Expense			
34	Ownership	61,771	34
C. Ancillary Expense			
35	Special Cost Centers	27,825	35
36	Provider Participation Fee	51,670	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,750,995	40
41	Income before Income Taxes (line 30 minus line 40)**	(817,077)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (817,077)	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.

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	1,008	1,307	\$ 47,534	\$ 36.37	1
2	Assistant Director of Nursing	398	397	4,881	12.29	2
3	Registered Nurses	7,355	8,494	202,729	23.87	3
4	Licensed Practical Nurses	9,213	10,348	234,308	22.64	4
5	CNAs & Orderlies	41,001	48,339	645,777	13.36	5
6	CNA Trainees	5,621	6,037	66,010	10.93	6
7	Licensed Therapist	0	0	0		7
8	Rehab/Therapy Aides	599	889	21,443	24.12	8
9	Activity Director	1,544	1,760	28,266	16.06	9
10	Activity Assistants	4,308	4,775	50,115	10.50	10
11	Social Service Workers	3,610	3,987	63,828	16.01	11
12	Dietician	0	0	0		12
13	Food Service Supervisor	1,648	1,760	44,286	25.16	13
14	Head Cook	5,435	5,943	67,319	11.33	14
15	Cook Helpers/Assistants	2,288	2,674	27,293	10.21	15
16	Dishwashers	15,218	16,827	177,692	10.56	16
17	Maintenance Workers	3,051	3,522	74,340	21.11	17
18	Housekeepers	9,536	10,611	112,580	10.61	18
19	Laundry	7,481	8,202	101,778	12.41	19
20	Administrator	1,371	1,442	26,016	18.04	20
21	Assistant Administrator	0	0	0		21
22	Other Administrative	224	477	25,059	52.53	22
23	Office Manager	216	240	4,605	19.19	23
24	Clerical	5,546	6,292	83,777	13.31	24
25	Vocational Instruction	0	0	0		25
26	Academic Instruction	0	0	0		26
27	Medical Director	1,472	1,643	22,623	13.77	27
28	Qualified MR Prof. (QMRP)	0	0	0		28
29	Resident Services Coordinator	0	0	0		29
30	Habilitation Aides (DD Homes)	0	0	0		30
31	Medical Records	0	0	0		31
32	Other Health Care: MDS Coordinator	2,610	2,882	77,858	27.02	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	130,753	148,848	\$ 2,210,117 *	\$ 14.85	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	116	\$ 3,183	1.3	35
36	Medical Director	0	0		36
37	Medical Records Consultant	31	1,983	10.3	37
38	Nurse Consultant	0	0	10.3	38
39	Pharmacist Consultant	36	1,100	10.3	39
40	Physical Therapy Consultant	13	845	10.3	40
41	Occupational Therapy Consultant	0	0		41
42	Respiratory Therapy Consultant	0	0		42
43	Speech Therapy Consultant	0	0		43
44	Activity Consultant	0	0		44
45	Social Service Consultant	50	3,010	12.3	45
46	Other(specify)	0	0		46
47					47
48					48
49	TOTAL (lines 35 - 48)	245	\$ 10,121		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	\$ 54,502	Workers' Compensation Insurance	\$ 58,428	IDPH License Fee	\$ 14,101		
				Unemployment Compensation Insurance	19,121	Advertising: Employee Recruitment			
				FICA Taxes	161,831	Health Care Worker Background Check			
				Employee Health Insurance	262,180	(Indicate # of checks performed _____)			
				Employee Meals		Patient Background Checks			
				Illinois Municipal Retirement Fund (IMRF)*					
				Less: Sisters' Maintenance Adjustment	(8,742)	Licenses and Dues	18,652		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 54,502			Less: Public Relations Expense	(2,181)		
B. Administrative - Other						Non-allowable advertising	()		
Description			Amount			Yellow page advertising	()		
This schedule is not applicable.						TOTAL (agree to Sch. V, line 20, col. 8)	\$ 30,572		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL (agree to Schedule V, line 22, col.8)	\$ 492,818				
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	
Brown Smith Wallace LLC	Audit & Accounting		\$ 14,490	This schedule is not applicable.			Out-of-State Travel	\$ None	
Kronos Inc.	Payroll Software		4,107						
Catholic Mutual Group	Insurance		4,000			In-State Travel	2,061		
Alliance Benefit Group	Employee Benefits Consulting		3,225						
Dr. Melvin Kaplan	Dental Services		1,824			Seminar Expense	3,862		
Heyl Royster Voelker	Legal		1,557			Vehicle Maintenance and Gas	3,316		
CBIZ Valuation	Fixed Asset Accounting		950						
Advanced Medical Transport	Ambulance		788			Entertainment Expense	NONE		
Proctor Hospital	Medical Services		647			(agree to Sch. V, line 24, col. 8)			
Red Wing Software	Network Support		529			TOTAL	\$ 9,239		
Others (less than \$500 each)	Various		3,336						
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 35,453	TOTAL		\$			

* Attach copy of IMRF notifications

**See instructions.

ST. JOSEPH NURSING HOME
SCHEDULE XIX, G, PAGE 21
SCHEDULE OF SEMINAR EXPENSE
Year Ended June 30, 2008

<u>Seminar Name</u>	<u>Employee(s)</u>	<u>Date</u>	<u>Cost</u>
Peoria Health Dept	Kimberly Kelly	08/31/07	\$60
HC Pro	Jeff Phillips	09/07/07	\$139
IAPA Conference	Anita Evans	09/27/07	\$250
Channel Inc	Zaida Murphy	10/04/07	\$79
	Sandy Colwell, Lori Maxedon, Joan		
Good Samaitan Home	Quigg, Deb Hagemeyer	10/23/07	\$100
Control Docs	Thomas Becher	11/28/07	\$1,213
Cross Country Education	Deb Hagemeyer	11/28/07	\$228
Brady Bistro Dietary	Deb Hagemeyer	12/27/07	\$117
Life Services Network	Thomas Becher, Sandy Colwell	02/01/08	\$99
The American Healthcare	Sandy Colwell	02/15/08	\$82
Fred Pryor Seminars	Jeff Phillips, Sister Agnes	03/28/08	\$198
The American Healthcare	Judy Kisse	03/28/08	\$81
Illinois Healthcare Assoc	Judy Kisse	03/28/08	\$210
Illinois Healthcare Assoc	Judy Kisse	03/28/08	\$122
Lincoln Land College	Judy Kisse	04/22/08	\$80
Career Track	Angela Mehlbrech	05/08/08	\$99
Nurses Aide Testing	Judy Kisse	05/14/08	\$105
American Red Cross	Joan Quigg	05/31/08	\$600
TOTAL			<u><u>\$3,862</u></u>

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6	THIS WORKSHEET IS NOT APPLICABLE.											
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$

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. CHA, AASHA, LSN, Lacon Chamber of Commerce
- (3) Did the nursing home make political contributions or payments to a political organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? OPEN
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 35,267 Line 10.2
- (7) Have all costs reported on this form been determined using accounting procedure consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO 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. \$ 51,670
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? Yes-See 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 benefit on Schedule V. \$ None Has any meal income been offset against related costs? Yes Indicate the amount. \$ 12,087
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? None
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: 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 service performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees

2024-01-01	Balance	100.00
2024-01-15	Transfer	50.00
2024-01-31	Balance	150.00
2024-02-15	Transfer	25.00
2024-02-28	Balance	175.00
2024-03-15	Transfer	75.00
2024-03-31	Balance	250.00
2024-04-15	Transfer	100.00
2024-04-30	Balance	350.00
2024-05-15	Transfer	150.00
2024-05-31	Balance	500.00
2024-06-15	Transfer	200.00
2024-06-30	Balance	700.00
2024-07-15	Transfer	250.00
2024-07-31	Balance	950.00
2024-08-15	Transfer	300.00
2024-08-31	Balance	1250.00
2024-09-15	Transfer	350.00
2024-09-30	Balance	1600.00
2024-10-15	Transfer	400.00
2024-10-31	Balance	2000.00
2024-11-15	Transfer	450.00
2024-11-30	Balance	2450.00
2024-12-15	Transfer	500.00
2024-12-31	Balance	2950.00
2025-01-01	Balance	2950.00
2025-01-15	Transfer	550.00
2025-01-31	Balance	3500.00
2025-02-15	Transfer	600.00
2025-02-28	Balance	4100.00
2025-03-15	Transfer	650.00
2025-03-31	Balance	4750.00
2025-04-15	Transfer	700.00
2025-04-30	Balance	5450.00
2025-05-15	Transfer	750.00
2025-05-31	Balance	6200.00
2025-06-15	Transfer	800.00
2025-06-30	Balance	7000.00
2025-07-15	Transfer	850.00
2025-07-31	Balance	7850.00
2025-08-15	Transfer	900.00
2025-08-31	Balance	8750.00
2025-09-15	Transfer	950.00
2025-09-30	Balance	9700.00
2025-10-15	Transfer	1000.00
2025-10-31	Balance	10700.00
2025-11-15	Transfer	1050.00
2025-11-30	Balance	11750.00
2025-12-15	Transfer	1100.00
2025-12-31	Balance	12850.00
2026-01-01	Balance	12850.00
2026-01-15	Transfer	1150.00
2026-01-31	Balance	14000.00
2026-02-15	Transfer	1200.00
2026-02-28	Balance	15200.00
2026-03-15	Transfer	1250.00
2026-03-31	Balance	16450.00
2026-04-15	Transfer	1300.00
2026-04-30	Balance	17750.00
2026-05-15	Transfer	1350.00
2026-05-31	Balance	19100.00
2026-06-15	Transfer	1400.00
2026-06-30	Balance	20500.00
2026-07-15	Transfer	1450.00
2026-07-31	Balance	21950.00
2026-08-15	Transfer	1500.00
2026-08-31	Balance	23450.00
2026-09-15	Transfer	1550.00
2026-09-30	Balance	25000.00
2026-10-15	Transfer	1600.00
2026-10-31	Balance	26600.00
2026-11-15	Transfer	1650.00
2026-11-30	Balance	28250.00
2026-12-15	Transfer	1700.00
2026-12-31	Balance	30000.00
2027-01-01	Balance	30000.00
2027-01-15	Transfer	1750.00
2027-01-31	Balance	31750.00
2027-02-15	Transfer	1800.00
2027-02-28	Balance	33550.00
2027-03-15	Transfer	1850.00
2027-03-31	Balance	35400.00
2027-04-15	Transfer	1900.00
2027-04-30	Balance	37300.00
2027-05-15	Transfer	1950.00
2027-05-31	Balance	39250.00
2027-06-15	Transfer	2000.00
2027-06-30	Balance	41250.00
2027-07-15	Transfer	2050.00
2027-07-31	Balance	43300.00
2027-08-15	Transfer	2100.00
2027-08-31	Balance	45400.00
2027-09-15	Transfer	2150.00
2027-09-30	Balance	47550.00
2027-10-15	Transfer	2200.00
2027-10-31	Balance	49750.00
2027-11-15	Transfer	2250.00
2027-11-30	Balance	52000.00
2027-12-15	Transfer	2300.00
2027-12-31	Balance	54300.00
2028-01-01	Balance	54300.00
2028-01-15	Transfer	2350.00
2028-01-31	Balance	56650.00
2028-02-15	Transfer	2400.00
2028-02-28	Balance	59050.00
2028-03-15	Transfer	2450.00
2028-03-31	Balance	61500.00
2028-04-15	Transfer	2500.00
2028-04-30	Balance	64000.00
2028-05-15	Transfer	2550.00
2028-05-31	Balance	66550.00
2028-06-15	Transfer	2600.00
2028-06-30	Balance	69150.00
2028-07-15	Transfer	2650.00
2028-07-31	Balance	71800.00
2028-08-15	Transfer	2700.00
2028-08-31	Balance	74500.00
2028-09-15	Transfer	2750.00
2028-09-30	Balance	77250.00
2028-10-15	Transfer	2800.00
2028-10-31	Balance	80050.00
2028-11-15	Transfer	2850.00
2028-11-30	Balance	82900.00
2028-12-15	Transfer	2900.00
2028-12-31	Balance	85800.00
2029-01-01	Balance	85800.00
2029-01-15	Transfer	2950.00
2029-01-31	Balance	88750.00
2029-02-15	Transfer	3000.00
2029-02-28	Balance	91750.00
2029-03-15	Transfer	3050.00
2029-03-31	Balance	94800.00
2029-04-15	Transfer	3100.00
2029-04-30	Balance	97900.00
2029-05-15	Transfer	3150.00
2029-05-31	Balance	101050.00
2029-06-15	Transfer	3200.00
2029-06-30	Balance	104250.00
2029-07-15	Transfer	3250.00
2029-07-31	Balance	107500.00
2029-08-15	Transfer	3300.00
2029-08-31	Balance	110800.00
2029-09-15	Transfer	3350.00
2029-09-30	Balance	114150.00
2029-10-15	Transfer	3400.00
2029-10-31	Balance	117550.00
2029-11-15	Transfer	3450.00
2029-11-30	Balance	121000.00
2029-12-15	Transfer	3500.00
2029-12-31	Balance	124500.00
2030-01-01	Balance	124500.00
2030-01-15	Transfer	3550.00
2030-01-31	Balance	128050.00
2030-02-15	Transfer	3600.00
2030-02-28	Balance	131650.00
2030-03-15	Transfer	3650.00
2030-03-31	Balance	135300.00
2030-04-15	Transfer	3700.00
2030-04-30	Balance	139000.00
2030-05-15	Transfer	3750.00
2030-05-31	Balance	142750.00
2030-06-15	Transfer	3800.00
2030-06-30	Balance	146550.00
2030-07-15	Transfer	3850.00
2030-07-31	Balance	150400.00
2030-08-15	Transfer	3900.00
2030-08-31	Balance	154300.00
2030-09-15	Transfer	3950.00
2030-09-30	Balance	158250.00
2030-10-15	Transfer	4000.00
2030-10-31	Balance	162250.00
2030-11-15	Transfer	4050.00
2030-11-30	Balance	166300.00
2030-12-15	Transfer	4100.00
2030-12-31	Balance	170400.00
2031-01-01	Balance	170400.00
2031-01-15	Transfer	4150.00
2031-01-31	Balance	174550.00
2031-02-15	Transfer	4200.00
2031-02-28	Balance	178750.00
2031-03-15	Transfer	4250.00
2031-03-31	Balance	183000.00
2031-04-15	Transfer	4300.00
2031-04-30	Balance	187300.00
2031-05-15	Transfer	4350.00
2031-05-31	Balance	191650.00
2031-06-15	Transfer	4400.00
2031-06-30	Balance	196050.00
2031-07-15	Transfer	4450.00
2031-07-31	Balance	200500.00
2031-08-15	Transfer	4500.00
2031-08-31	Balance	205000.00
2031-09-15	Transfer	4550.00
2031-09-30	Balance	209550.00
2031-10-15	Transfer	4600.00
2031-10-31	Balance	214150.00
2031-11-15	Transfer	4650.00
2031-11-30	Balance	218800.00
2031-12-15	Transfer	4700.00
2031-12-31	Balance	223500.00
2032-01-01	Balance	223500.00
2032-01-15	Transfer	4750.00
2032-01-31	Balance	228250.00
2032-02-15	Transfer	4800.00
2032-02-28	Balance	233050.00
2032-03-15	Transfer	4850.00
2032-03-31	Balance	237900.00
2032-04-15	Transfer	4900.00
2032-04-30	Balance	242800.00
2032-05-15	Transfer	4950.00
2032-05-31	Balance	247750.00
2032-06-15	Transfer	5000.00
2032-06-30	Balance	252750.00
2032-07-15	Transfer	5050.00
2032-07-31	Balance	257800.00
2032-08-15	Transfer	5100.00
2032-08-31	Balance	262900.00
2032-09-15	Transfer	5150.00
2032-09-30	Balance	268050.00
2032-10-15	Transfer	5200.00
2032-10-31	Balance	273250.00
2032-11-15	Transfer	5250.00
2032-11-30	Balance	278500.00
2032-12-15	Transfer	5300.00
2032-12-31	Balance	283800.00
2033-01-01	Balance	283800.00
2033-01-15	Transfer	5350.00
2033-01-31	Balance	289150.00
2033-02-15	Transfer	5400.00
2033-02-28	Balance	294550.00
2033-03-15	Transfer	5450.00
2033-03-31	Balance	300000.00
2033-04-15	Transfer	5500.00
2033-04-30	Balance	305500.00
2033-05-15	Transfer	5550.00
2033-05-31	Balance	311050.00
2033-06-15	Transfer	5600.00
2033-06-30	Balance	316650.00
2033-07-15	Transfer	5650.00
2033-07-31	Balance	322300.00
2033-08-15	Transfer	5700.00
2033-08-31	Balance	328000.00
2033-09-15	Transfer	5750.00
2033-09-30	Balance	333750.00
2033-10-15	Transfer	5800.00
2033-10-31	Balance	339550.00
2033-11-15	Transfer	5850.00
2033-11-30	Balance	345400.00
2033-12-15	Transfer	5900.00
2033-12-31	Balance	351300.00
2034-01-01	Balance	351300.00
2034-01-15	Transfer	5950.00
2034-01-31	Balance	357250.00
2034-02-15	Transfer	6000.00
2034-02-28	Balance	363250.00
2034-03-15	Transfer	6050.00
2034-03-31	Balance	369300.00
2034-04-15	Transfer	6100.00
2034-04-30	Balance	375400.00
2034-05-15	Transfer	6150.00
2034-05-31	Balance	381550.00
2034-06-15	Transfer	6200.00
2034-06-30	Balance	387750.00
2034-07-15	Transfer	6250.00
2034-07-31	Balance	394000.00
2034-08-15	Transfer	6300.00
2034-08-31	Balance	400300.00
2034-09-15	Transfer	6350.00
2034-09-30	Balance	406650.00
2034-10-15	Transfer	6400.00
2034-10-31	Balance	413050.00
2034-11-15	Transfer	6450.00
2034-11-30	Balance	419500.00
2034-12-15	Transfer	6500.00
2034-12-31	Balance	426000.00
2035-01-01	Balance	426000.00
2035-01-15	Transfer	6550.00
2035-01-31	Balance	432550.00
2035-02-15	Transfer	6600.00
2035-02-28	Balance	439150.00
2035-03-15	Transfer	6650.00
2035-03-31	Balance	445800.00
2035-04-15	Transfer	6700.00
2035-04-30	Balance	452500.00
2035-05-15	Transfer	6750.00
2035-05-31	Balance	459250.00
2035-06-15	Transfer	6800.00
2035-06-30	Balance	466050.00
2035-07-15	Transfer	6850.00
2035-07-31	Balance	472900.00
2035-08-15	Transfer	6900.00
2035-08-31	Balance	479800.00
2035-09-15	Transfer	6950.00
2035-09-30	Balance	486750.00
2035-10-15	Transfer	7000.00
2035-10-31	Balance	493750.00
2035-11-15	Transfer	7050.00
2035-11-30	Balance	500800.00
2035-12-15	Transfer	7100.00
2035-12-31	Balance	507900.00
2036-01-01	Balance	507900.00
2036-01-15	Transfer	7150.00
2036-01-31	Balance	515050.00
2036-02-15	Transfer	7200.00
2036-02-28	Balance	522250.00
2036-03-15	Transfer	7250.00
2036-03-31	Balance	529500.00
2036-04-15	Transfer	7300.00
2036-04-30	Balance	536800.00
2036-05-15	Transfer	7350.00
2036-05-31	Balance	544150.00
2036-06-15	Transfer	7400.00
2036-06-30	Balance	551550.00
2036-07-15	Transfer	7450.00
2036-07-31	Balance	559000.00
2036-08-15	Transfer	7500.00
2036-08-31	Balance	566500.00
2036-09-15	Transfer	7550.00
2036-09-30	Balance	574050.00
2036-10-15		