

		FOR BHF USE					

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2009
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2009)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p>I. IDPH License ID Number: <u>0005637</u></p> <p>Facility Name: <u>ST. JOSEPH NURSING HOME</u></p> <p>Address: <u>401 NINTH STREET</u> <u>LACON</u> <u>61540</u> Number City Zip Code</p> <p>County: <u>MARSHALL</u></p> <p>Telephone Number: <u>(309) 246-2175</u> Fax # <u>(309) 246-3609</u></p> <p>HFS ID Number: <u>0005637</u></p> <p>Date of Initial License for Current Owners: <u>1964</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input checked="" type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>LARRY PEVNICK</u> Telephone Number: <u>(314) 983-1247</u> Email Address: <u>LPEVNICK@BSWLLC.COM</u></p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>7/1/2008</u> to <u>6/30/2009</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2" style="width: 15%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Type or Print Name) <u>ANGELA MEHLBRECH</u></td> <td></td> </tr> <tr> <td></td> <td>(Title) <u>ADMINISTRATOR</u></td> <td></td> </tr> <tr> <td rowspan="4">Paid Preparer</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>LARRY PEVNICK</u> <u>MEMBER</u></td> <td></td> </tr> <tr> <td>(Firm Name & Address) <u>BROWN SMITH WALLACE, L.L.C.</u> <u>1050 NORTH LINDBERGH BLVD.</u></td> <td></td> </tr> <tr> <td>(Telephone) <u>(314) 983-1200</u> Fax # <u>(314) 983-1300</u></td> <td></td> </tr> </table> <p>MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____	(Date) _____	(Type or Print Name) <u>ANGELA MEHLBRECH</u>			(Title) <u>ADMINISTRATOR</u>		Paid Preparer	(Signed) _____	(Date) _____	(Print Name and Title) <u>LARRY PEVNICK</u> <u>MEMBER</u>		(Firm Name & Address) <u>BROWN SMITH WALLACE, L.L.C.</u> <u>1050 NORTH LINDBERGH BLVD.</u>		(Telephone) <u>(314) 983-1200</u> Fax # <u>(314) 983-1300</u>	
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Facility Name & ID Number ST. JOSEPH NURSING HOME

0005637 Report Period Beginning: 7/1/2008 Ending: 6/30/2009

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	839	1,458	2,539	4,836	8
9	SNF/PED					9
10	ICF	16,129	8,636	0	24,765	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,968	10,094	2,539	29,601	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.20%

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 93 and days of care provided 2,539

Medicare Intermediary NGS

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 7/1/2008-6/30/2009 Fiscal Year: 7/1/08-6/30/2008

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

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	296,316		29,191	325,507		325,507	(32,515)	292,992		1
2	Food Purchase		224,479		224,479		224,479	(92,509)	131,970		2
3	Housekeeping	90,298	15,771		106,069		106,069		106,069		3
4	Laundry	105,975		7,676	113,651		113,651		113,651		4
5	Heat and Other Utilities			149,649	149,649		149,649	(5,532)	144,117		5
6	Maintenance	77,136		27,544	104,680		104,680		104,680		6
7	Other (specify):*										7
8	TOTAL General Services	569,725	240,250	214,060	1,024,035		1,024,035	(130,556)	893,479		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	1,286,386	86,975	71,491	1,444,852		1,444,852		1,444,852		10
10a	Therapy			268,135	268,135		268,135		268,135		10a
11	Activities	77,617	3,952	1,275	82,844		82,844		82,844		11
12	Social Services	77,520	318	2,010	79,848		79,848		79,848		12
13	CNA Training			580	580		580		580		13
14	Program Transportation										14
15	Other (specify):* Bad Debt Expense			34,523	34,523		34,523		34,523		15
16	TOTAL Health Care and Programs	1,441,523	91,245	378,014	1,910,782		1,910,782		1,910,782		16
	C. General Administration										
17	Administrative										17
18	Directors Fees										18
19	Professional Services			385,836	385,836		385,836		385,836		19
20	Dues, Fees, Subscriptions & Promotions			36,607	36,607		36,607		36,607		20
21	Clerical & General Office Expenses	120,704	11,422	46,339	178,465		178,465	6,736	185,201		21
22	Employee Benefits & Payroll Taxes			631,495	631,495		631,495	(8,767)	622,728		22
23	Inservice Training & Education										23
24	Travel and Seminar			11,357	11,357		11,357		11,357		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			35,600	35,600		35,600		35,600		26
27	Other (specify):*										27
28	TOTAL General Administration	120,704	11,422	1,147,234	1,279,360		1,279,360	(2,031)	1,277,329		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,131,952	342,917	1,739,308	4,214,177		4,214,177	(132,588)	4,081,589		29

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

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

Facility Name & ID Number

ST. JOSEPH NURSING HOME

#0005637

Report Period Beginning:

7/1/2008

Ending:

6/30/2009

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			57,441	57,441		57,441		57,441			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			6,558	6,558		6,558	(6,558)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			63,999	63,999		63,999	(6,558)	57,441			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			96,260	96,260		96,260		96,260			39
40	Barber and Beauty Shops		226	9,719	9,945		9,945		9,945			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			50,918	50,918		50,918		50,918			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		226	156,897	157,123		157,123		157,123			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,131,952	343,143	1,960,204	4,435,299		4,435,299	(139,146)	4,296,153			45

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

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

0005637

Report Period Beginning: **7/1/2008**

Ending: **6/30/2009**

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-	BHF USE	
			ence	ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	16,760	2		4
5	Telephone, TV & Radio in Resident Rooms	6,736	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				9
10	Interest and Other Investment Income	(6,558)	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	(86,846)	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		20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (69,908)		\$	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 PG24	69,238		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 69,238		36
	(sum of SUBTOTALS)			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (670)		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

ST. JOSEPH NURSING HOMEID# 0005637Report Period Beginning: 7/1/2008Ending: 6/30/2009

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Sisters' Portion of Dietary Costs	\$ (32,515)	1	1
2	Sisters' Portion of Food Costs	(22,423)	2	2
3	Sisters' Portion of Heat and Other Utilities	(5,532)	5	3
4	Sisters' Portion of Employee Benefits in Meals	(8,767)	22	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				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		(69,238)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number ST. JOSEPH NURSING HOME# 0005637

Report Period Beginning:

7/1/2008

Ending:

6/30/2009

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

	Operating Expenses	PAGES	PAGE	SUMMARY										
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
		(to Sch V, col.7)												
1	Dietary	(32,515)	0	0	0	0	0	0	0	0	0	0	(32,515)	1
2	Food Purchase	(92,509)	0	0	0	0	0	0	0	0	0	0	(92,509)	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	(5,532)	0	0	0	0	0	0	0	0	0	0	(5,532)	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	(130,556)	0	(130,556)	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	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	6,736	0	0	0	0	0	0	0	0	0	0	6,736	21
22	Employee Benefits & Payroll Taxes	(8,767)	0	0	0	0	0	0	0	0	0	0	(8,767)	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	(2,031)	0	(2,031)	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(132,588)	0	(132,588)	29									

STATE OF ILLINOIS

Summary B

Facility Name & ID Number ST. JOSEPH NURSING HOME# 0005637

Report Period Beginning:

7/1/2008 Ending:

6/30/2009

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	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(6,558)	0	0	0	0	0	0	0	0	0	0	(6,558)	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	(6,558)	0	0	0	0	0	0	0	0	0	0	(6,558)	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
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(139,146)	0	0	0	0	0	0	0	0	0	0	(139,146)	45

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

0005637

Report Period Beginning:

7/1/2008

Ending:

6/30/2009

VII. RELATED PARTIES

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

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

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

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

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

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

Facility Name & ID Number ST. JOSEPH NURSING HOME # 0005637 Report Period Beginning: 7/1/2008 Ending: 6/30/2009

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$	1	
2	THIS WORKSHEET IS NOT APPLICABLE.										2
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:

7/1/2008

Ending: 7/30/2009

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:

7/1/2008

Ending:

6/30/2009

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required				Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
A. Directly Facility Related																	
Long-Term																	
1	DAUGHTERS OF ST. FRANCIS OF						\$	\$			\$						
2	ASSISI (MOTHERHOUSE)	X		WORKING CAPITAL	\$1,000.00	VARIOUS	204,400	16,000	NONE	NONE							
3	BANK OF LACON		X	WORKING CAPITAL	\$1,615.00	8/11/2005	350,000	265,558	11/15/09	6.5000							
4																	
5																	
Working Capital																	
6																	
7																	
8																	
9	TOTAL Facility Related				\$2,615.00		\$ 554,400	\$ 281,558			\$						
B. Non-Facility Related*																	
10																	
11																	
12																	
13																	
14	TOTAL Non-Facility Related						\$	\$			\$						
15	TOTALS (line 9+line14)						\$ 554,400	\$ 281,558			\$						

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

1. Real Estate Tax accrual used on 2008 report.								
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.)								
3. Under or (over) accrual (line 2 minus line 1).								
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)								
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.)								
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.)								
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.								

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2004	_____	8
	2005	_____	9
	2006	_____	10
	2007	_____	11
	2008	_____	12

	FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2008	\$		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:** 2008 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 2008 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2008.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2008 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 2009 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.

2008 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME ST. JOSEPH NURSING HOME COUNTY MARSHALL

FACILITY IDPH LICENSE NUMBER 0005637

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2008 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 2008.

	(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.	THIS WORKSHEET IS NOT APPLICABLE.		\$ _____	\$ _____
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 and 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 2008 tax bills which were listed in Section A to this statement. Be sure to use the 2008 tax bill which is normally paid during 2009.

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 ST. JOSEPH NURSING HOME

0005637 Report Period Beginning:

7/1/2008 Ending:

6/30/2009

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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	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:

7/1/2008

Ending:

6/30/2009

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		20			28,119	20
21	IDPA AUDIT ADJUSTMENTS		1977	11,869		20			7,246	21
22	IDPA AUDIT ADJUSTMENTS		1986	94,429		VARIOUS			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		VARIOUS			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		10			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.

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	CERAMIC FLOOR FOR NEW TUB	1999	\$ 107	\$ 5	20	\$ 5	\$	\$ 53	37
38	CARPET ON WALLS	2000	2,668		5			2,668	38
39	METAMORA TELEPHONE SYSTEM	2000	7,337	734	10	734		6,973	39
40	TOMKAT ROOFING	2001	18,760	1,876	10	1,876		15,946	40
41	HOBERT CORP	2001	1,555	156	10	156		1,326	41
42	ASPHALT REPAIR	2002	2,900	363	8	363		2,722	42
43									43
44	75 GALLON 365M ASME WTR HTR	2006	5,225	523	10	523		1,830	44
45	ULTRA CARE 709 BED LAMINATE PANELS	2006	5,809	387	15	387		1,354	45
46	HOYER PROF PATIENT LIFT	2006	3,020	302	10	302		1,057	46
47	HOYER PROF VERTICAL PATIENT LIFT W/ SCALE	2006	4,249	424	10	424		1,484	47
48									48
49	CONCRETE SIDEWALK	2007	5,220	348	15	348		870	49
50	ROOFING	2007	20,986	2,098	10	2,098		5,245	50
51	FIRE DAMPERS	2007	13,100	874	15	874		2,185	51
52	BEDS (16)	2007	19,904	1,328	15	1,328		3,320	52
53	DOOR ALARM SYSTEM	2007	20,963	1,398	15	1,398		3,495	53
54	FURNITURE & EQUIPMENT - NURSING SERVICE	2008	21,360	785	15	785		1,570	54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,555,183	\$ 11,601		\$ 11,601	\$	\$ 2,421,442	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	\$ 45,840	\$ 45,840	\$		\$ 164,500	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	465,884					465,884	73
74								74
75	TOTALS	\$ 624,537	\$ 45,840	\$ 45,840	\$		\$ 630,384	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)	\$ 57,441	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 57,441	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)	\$ 3,101,516	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

10. Effective dates of current rental agreement:

Beginning _____
Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /2010 \$ _____
13. _____ /2011 \$ _____
14. _____ /2012 \$ _____

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental? YES NO
16. Rental Amount for movable equipment: \$ _____ Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number ST. JOSEPH NURSING HOME # 0005637 Report Period Beginning: 7/1/2008 Ending: 6/30/2009
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. 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		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	5 Units Cost					
					Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$			1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits		THIS WORKSHEET IS NOT APPLICABLE.			#VALUE!		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			\$		\$	\$	#VALUE!	\$	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 **ST. JOSEPH NURSING HOME**# **0005637**Report Period Beginning: **7/1/2008**

Ending:

6/30/2009**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **6/30/2009** (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	\$ 266,404	\$	1
2	Cash-Patient Deposits	2,015		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 34,302)	880,312		3
4	Supply Inventory (priced at COST)	35,781		4
5	Short-Term Investments			5
6	Prepaid Insurance	1,936		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Medicare receivable	6,144		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,192,592	\$	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	1,324,646		16
17	Accumulated Depreciation (book methods)	(2,802,525)		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)	\$ 391,636	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,584,228	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 303,678	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	302,126		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	265,558		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 871,362	\$	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	16,000		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 16,000	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 887,362	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 696,866	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,584,228	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 656,180	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 656,180	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	40,686	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)	\$ 40,686	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)	\$ 696,866	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number **ST. JOSEPH NURSING HOME**# **0005637**Report Period Beginning: **7/1/2008**Ending: **6/30/2009**

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	\$ 5,505,354	1	
2	Discounts and Allowances for all Levels	(1,184,762)	2	
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,320,592	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	163	12	
13	Barber and Beauty Care	13,222	13	
14	Non-Patient Meals	16,760	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	86,846	21	
22	Laundry		22	
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 116,991	23	
D. Non-Operating Revenue				
24	Contributions	17,911	24	
25	Interest and Other Investment Income***	955	25	
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 18,866	26	
E. Other Revenue (specify):****				
27	Settlement Income (Insurance, Legal, Etc.)		27	
28	Sisters' Maintenance	19,536	28	
28a			28a	
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 19,536	29	
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,475,985	30	

		2		
Expenses		Amount		
A. Operating Expenses				
31	General Services	1,024,035	31	
32	Health Care	1,910,782	32	
33	General Administration	1,279,360	33	
B. Capital Expense				
34	Ownership	63,999	34	
C. Ancillary Expense				
35	Special Cost Centers	106,205	35	
36	Provider Participation Fee	50,918	36	
D. Other Expenses (specify):				
37			37	
38			38	
39			39	
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,435,299	40	
41	Income before Income Taxes (line 30 minus line 40)**	40,686	41	
42	Income Taxes		42	
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 40,686	43	

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

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

0005637

Report Period Beginning: **7/1/2008**

Ending:

6/30/2009

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	1,304	1,520	\$ 40,242	\$ 26.48	1
2	Assistant Director of Nursing	704	712	20,979	29.46	2
3	Registered Nurses	7,450	8,727	192,810	22.09	3
4	Licensed Practical Nurses	12,565	14,208	271,911	19.14	4
5	CNAs & Orderlies	52,974	60,062	616,099	10.26	5
6	CNA Trainees	2,135	2,431	22,740	9.35	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	43	43	676	15.72	8
9	Activity Director	1,736	2,000	27,863	13.93	9
10	Activity Assistants	5,638	6,153	52,814	8.58	10
11	Social Service Workers	5,459	5,875	77,675	13.22	11
12	Dietician	0				12
13	Food Service Supervisor	1,744	2,000	44,003	22.00	13
14	Head Cook	5,732	6,510	61,323	9.42	14
15	Cook Helpers/Assistants	3,311	3,643	30,923	8.49	15
16	Dishwashers	17,775	20,158	176,660	8.76	16
17	Maintenance Workers	4,102	4,651	78,669	16.91	17
18	Housekeepers	9,146	10,551	94,288	8.94	18
19	Laundry	9,615	11,102	113,859	10.26	19
20	Administrator	1,896	2,080	32,560	15.65	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,892	6,585	73,736	11.20	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director	1,879	2,151	26,748	12.44	27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: <u>MDS Coordinator</u>	3,205	3,477	75,374	21.68	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	154,305	174,639	\$ 2,131,952 *	\$ 12.21	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	0	\$ 6,142	1.3	35
36	Medical Director	0	0		36
37	Medical Records Consultant	0	0		37
38	Nurse Consultant	0	0		38
39	Pharmacist Consultant	0	1,500	10.3	39
40	Physical Therapy Consultant	0	0		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	0	2,010	12.3	45
46	Other(specify)	0	0		46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 9,652		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		
Angela Mehlbrech	Administrator	0	0	Workers' Compensation Insurance	\$ 68,957	IDPH License Fee	\$		
				Unemployment Compensation Insurance	16,387	Advertising: Employee Recruitment	22,612		
				FICA Taxes	291,816	Health Care Worker Background Check (Indicate # of checks performed _____)			
				Employee Health Insurance	263,102	Patient Background Checks			
				Employee Meals					
				Illinois Municipal Retirement Fund (IMRF)*					
				Less: Sisters' Maintenance Adjustment	(8,767)	Licenses and Dues	13,995		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)									
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)		
Description			Amount				Less: Public Relations Expense ()		
			\$				Non-allowable advertising ()		
							Yellow page advertising ()		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$						
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Vendor/Payee	Type	Amount		Description	Line #	Amount	Description	Amount	
Provena	Management Fees	\$ 249,114		This schedule is not applicable.			Out-of-State Travel	\$ None	
Pearl Technology	Network Support	20,320							
Fidelity on Call	Nursing Staffing	54,639							
Management Resource	Executive Staffing	16,500						In-State Travel	618
Brown Smith Wallace, L.L.C.	Audit & Accounting	15,030							
CMS Labs	Medical Services	4,874							
S&S Builders	Fire Doors Services	4,353							
Tallyn's Data Recover	Network Support	3,718						Seminar Expense	3,327
Alliance Benefit Group	Employee Benefits Consulting	3,130							
Kronos Inc.	Payroll Software	2,579						Vehicle Maintenance and Gas	7,412
Life Services Networks	Insurance	1,935							
Others See PG25	Various	9,644					Entertainment Expense	NONE	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)				\$ 385,836	TOTAL				
							TOTAL (agree to Sch. V, line 24, col. 8)		\$ 11,357

* Attach copy of IMRF notifications

**See instructions.

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	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014
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	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number ST. JOSEPH NURSING HOME

0005637

Report Period Beginning: 7/1/2008

Ending: 6/30/2009

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 action organization? NO If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? OPEN
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 35,521 Line 10.2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 50,918
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? YES-SEE ADJUSTMENT 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. \$ NONE Has any meal income been offset against related costs? YES Indicate the amount. \$ 16,760
- (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? In process
Firm Name: BROWN SMITH WALLACE, LLC
- (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.

ST. JOSEPH NURSING HOME

PAGE 5A - NON-ALLOWABLE EXPENSES (RECLASSES AND ADJUSTMENTS) DETAIL

Reporting Period Beginning JULY 1, 2008 and Ending JUNE 30, 2009

Patient, Sister and Employee Meals:

		Detail	Subtotals	Percentages
<i>Meals served to Patients:</i>	Patient Days	29,601		
	Meals per day	3	88,803	90.01%
<i>Meals provided to Sisters (non-patient):</i>	Number of Sisters	9		
	Meals per day	3		
	Days per year	365	9,855	9.99%
Total Meals Served			98,658	100.00%

Adjustments for Sisters' Maintenance:

Sisters' portion of dietary and food cost:

Dietary cost	\$ 325,507	<i>From page 3, Line 1, Col. 4</i>
Sisters' percentage	9.99%	<i>From calculation above</i>
Sisters' Portion of Dietary Cost	\$ 32,515	<i>Adjustment: To Line 1, Schedule V</i>
Food cost	\$ 224,479	<i>From page 3, Line 2, Col. 4</i>
Sisters' percentage	9.99%	<i>From calculation above</i>
Sisters' Portion of Food Cost	\$ 22,423	<i>Adjustment: To Line 2, Schedule V</i>

Sisters' portion of building and utilities:

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

Sisters' portion of utilities:

Heat and Other Utilities	\$ 149,649	<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	\$ 5,532	<i>Adjustment: To Line 5, Schedule V</i>

Employee Benefits in Sisters' Meals:

Dietary Salaries	\$ 296,316	<i>From page 3, Line 1, Col. 1</i>
Sisters' percentage	9.99%	<i>From calculation above</i>
Salaries Applicable to Sister's Meals	\$ 29,599	
Total Salaries	\$ 2,131,952	<i>From page 4, Line 45, Col. 1</i>
Employee Benefits	\$ 631,495	<i>From page 3, Line 22, Col. 4</i>
Employee benefits ratio	29.62%	
Employee Benefits Applicable to Sisters' Meals	\$ 8,767	<i>Adjustment: To Line 22, Schedule V</i>

Total Adjustments for Sisters' Portion of Costs **\$ 69,238**

ST. JOSEPH NURSING HOME

PAGE 21 - Professional Services - Additional items not included on the standard schedule

Reporting Period Beginning JULY 1, 2008 and Ending JUNE 30, 2009

Vendor/Payee	Type	Amount
<u>OSF Medical</u>	<u>Medical Services</u>	\$ <u>1,016</u>
<u>CBIZ Valuation</u>	<u>Fixed Asset Accounting</u>	<u>1,011</u>
<u>Dr Melvin Kaplan</u>	<u>Dentist</u>	<u>848</u>
<u>Procare Home Health</u>	<u>Medical Services</u>	<u>780</u>
<u>IDFPR OF Professions</u>	<u>Medical Services</u>	<u>608</u>
<u>Greenberg & Associate</u>	<u>Medical Records Consultant</u>	<u>1,266</u>
<u>Others (less than \$500 each)</u>	<u>Various</u>	<u>4,115</u>
TOTAL (agree to PG21 Sch C, Other)		\$ <u><u>9,644</u></u>

ST. JOSEPH NURSING HOME

Schedule V - Detail of Line 24 (Total Exceeds \$2,000)

Reporting Period Beginning JULY 1, 2008 and Ending JUNE 30, 2009

V--24.3 Travel and Seminar Other

410039-00	Travel	618.00
410219-00	Education	3,327.00
510019-00	Vehicle Maint. & Gas Etc	<u>7,412.00</u>
		<u><u>11,357.00</u></u>