FOR BHF USE

LL1

2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

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

I. IDPH License ID Number: 0005520

Facility Name: Mount St Joseph

Address: 24955 North Highway 12 (Number) Lake Zurich (City) 60047 (Zip Code)

County: Lake

Telephone Number: 847-438-5050 **Fax #** 847-719-1060

HFS ID Number:

Date of Initial License for Current Owners: 1947

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

IRS Exemption Code

In the event there are further questions about this report, please contact:
Name: Robert Gaudio **Telephone Number:** 847-438-5050 X108
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/09 to 06/30/10 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name) SR. GERTRUDE LA BARBERA
(Title) EXECUTIVE DIRECTOR

Paid Preparer

(Signed) (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Mount St Joseph # 0005520 Report Period Beginning: 07/01/09 Ending: 06/30/10

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	43,133	732		43,865	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	43,133	732		43,865	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.04%

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 [X] NO [ ]

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

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

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

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

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 6/30/10 Fiscal Year: 6/30/10

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

Facility Name & ID Number Mount St Joseph # 0005520 Report Period Beginning: 07/01/09 Ending: 06/30/10

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	111,090		7,349	118,439		118,439	(11,844)	106,595			1
2	Food Purchase		95,876		95,876		95,876	(9,588)	86,288			2
3	Housekeeping	344,900	4,512		349,412		349,412		349,412			3
4	Laundry	41,768	1,442		43,210		43,210		43,210			4
5	Heat and Other Utilities			217,577	217,577		217,577	(8,703)	208,874			5
6	Maintenance	241,520	92,720		334,240		334,240		334,240			6
7	Other (specify):*											7
8	TOTAL General Services	739,278	194,550	224,926	1,158,754		1,158,754	(30,135)	1,128,620			8
	B. Health Care and Programs											
9	Medical Director	20,000			20,000		20,000		20,000			9
10	Nursing and Medical Records	1,940,178		13,161	1,953,339	(6,000)	1,947,339		1,947,339			10
10a	Therapy	61,702			61,702		61,702		61,702			10a
11	Activities											11
12	Social Services	16,857		4,000	20,857		20,857		20,857			12
13	CNA Training					6,000	6,000		6,000			13
14	Program Transportation			24,718	24,718		24,718		24,718			14
15	Other (specify):* DAY TRAINING	263,768	13,106	375,917	652,791		652,791	(624,103)	28,688			15
16	TOTAL Health Care and Programs	2,302,505	13,106	417,796	2,733,407		2,733,407	(624,103)	2,109,304			16
	C. General Administration											
17	Administrative	87,750	24,242		111,992	(10,891)	101,101		101,101			17
18	Directors Fees											18
19	Professional Services			81,251	81,251		81,251		81,251			19
20	Dues, Fees, Subscriptions & Promotions			27,628	27,628		27,628		27,628			20
21	Clerical & General Office Expenses	179,013	12,173		191,186		191,186		191,186			21
22	Employee Benefits & Payroll Taxes			500,408	500,408		500,408	(28,688)	471,720			22
23	Inservice Training & Education											23
24	Travel and Seminar			110	110		110		110			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			77,592	77,592		77,592		77,592			26
27	Other (specify):*											27
28	TOTAL General Administration	266,763	36,415	686,989	990,167	(10,891)	979,276	(28,688)	950,588			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,308,546	244,071	1,329,711	4,882,328	(10,891)	4,871,437	(682,926)	4,188,512			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Mount St Joseph #0005520 Report Period Beginning: 07/01/09 Ending: 06/30/10

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			482,540	482,540		482,540	81,009	563,549			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			180,000	180,000		180,000	(180,000)				34
35	Rent-Equipment & Vehicles					10,891	10,891		10,891			35
36	Other (specify):*											36
37	TOTAL Ownership			662,540	662,540	10,891	673,431	(98,991)	574,440			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			322,160	322,160		322,160		322,160			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			322,160	322,160		322,160		322,160			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,308,546	244,071	2,314,411	5,867,028		5,867,028	(781,917)	5,085,112			45

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

Facility Name & ID Number Mount St Joseph # 0005520 Report Period Beginning: 07/01/09 Ending: 06/30/10

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs	(21,432)	L!&2		3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(624,103)	L15		13
14	Non-Care Related Interest	(28,688)	L22		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(8,703)	L5		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (682,926)		$	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 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(98,991)	VII L14	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (98,991)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (781,917)		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 Yes	2 No	3 Amount	4 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

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Mount St Joseph

ID# 0005520

Report Period Beginning: 07/01/09

Ending: 06/30/10

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3	GOVERNMENTAL SPONSORED PROGRAMS	(21,432)	L1 & L2	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	DEVELOPMENTAL DAY TRAINING	(624,103)	L15	23
24	PAYROLL TAX DAY TRAINING	(28,688)	L22	24
25				25
26				26
27				27

Sch V	Adj. Summary
Line 1	0
Line 2	0
Line 3	0
Line 4	0
Line 5	0
Line 6	0
Line 7	0
Line 8	0
Line 9	0
Line 10	0
Line 10a	0
Line 11	0
Line 12	0
Line 13	0
Line 14	0
Line 15	0
Line 16	0
Line 17	0
Line 18	0
Line 19	0
Line 20	0
Line 21	0
Line 22	0
Line 23	0
Line 24	0
Line 25	0

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Mount St Joseph

ID# **0005520**

Report Period Beginning: **07/01/09**

Ending: **06/30/10**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
28				28
29	UTILITIES	(8,703)	L5	29
30	**SUBTOTAL (A):**			30
31				31
32				32
33				33
34	RELATED ORGANIZATIONS COSTS	(98,991)	VII L14	34
35				35
36	SUBTOTAL (B):			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**	(781,917)		49

Line 26	0
Line 27	0
Line 28	0
Line 29	0
Line 30	0
Line 31	0
Line 32	0
Line 33	0
Line 34	0
Line 35	0
Line 36	0
Line 37	0
Line 38	0
Line 39	0
Line 40	0
Line 41	0
Line 42	0
Line 43	0
Line 44	0
Line 45	0

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Mount St Joseph # 0005520 **Report Period Beginning:** 07/01/09 **Ending:** 06/30/10

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	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	0	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**	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	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**	0	0	0	0	0	0	0	0	0	0	0	0	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	0	0	0	0	0	0	0	0	0	0	0	0	29

Facility Name & ID Number Mount St Joseph **#** 0005520 **Report Period Beginning:** 07/01/09 **Ending:** 06/30/10

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

	Capital Expense / D. Ownership	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)	
30	Depreciation	0	81,009	0	0	0	0	0	0	0	0	0	81,009	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(180,000)	0	0	0	0	0	0	0	0	0	(180,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	(98,991)	0	0	0	0	0	0	0	0	0	(98,991)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	0	(98,991)	0	0	0	0	0	0	0	0	0	(98,991)	45

Facility Name & ID Number Mount St Joseph # 0005520 Report Period Beginning: 07/01/09 Ending: 06/30/10

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Daughters of St Mary of Providence	100					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		Rent	$ (180,000)	Daughters of St Mary of Providence	100.00%	$	$ 180,000	1
2	V		Depreciation	81,009	Daughters of St Mary of Providence	100.00%		(81,009)	2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ (98,991)			$	$ * 98,991	14

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

Facility Name & ID Number Mount St Joseph # 0005520 Report Period Beginning: 07/01/09 Ending: 06/30/10

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	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	GERTRUDE LABARBERA	SUPERIOR	C.E.O.	0.00	0	84	100.00	Stipend	$ 58,500	L 17 C 1	1
2	MARY WALKER	ADMINISTRATOR	DIRECTOR	0.00	0	84	100.00	Stipend	29,250	L 17 C 1	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 87,750		13

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

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

Facility Name & ID Number Mount St Joseph # 0005520 Report Period Beginning: 07/01/09 Ending: 06/30/10

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 [X]

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

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

	1 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	N/A					$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Mount St Joseph # 0005520 **Report Period Beginning:** 07/01/09 **Ending:** 06/30/10

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	N/A						$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Mount St Joseph # 0005520 **Report Period Beginning:** 07/01/09 **Ending:** 06/30/10

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ N/A	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$ ------	3
4. Real Estate Tax accrual used for 2010 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.)**		$ TAX EXEMPT	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:			
	2005		8
	2006		9
	2007		10
	2008		11
	2009		12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2009	$	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.

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Mount St Joseph COUNTY Lake

FACILITY IDPH LICENSE NUMBER 0005520

CONTACT PERSON REGARDING THIS REPORT Robert Gaudio

TELEPHONE 847-438-5050 ext. 108 FAX #: 847-719-1060

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

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

If YES, attach an explanation 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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number Mount St Joseph # 0005520 Report Period Beginning: 07/01/09 Ending: 06/30/10

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 168,131 B. General Construction Type: Exterior BRICK Frame BRICK Number of Stories 2

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (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? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

DEVELOPMENTAL TRAINING 1,010 SQUARE FEET

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	HOME	160 ACRES or	1935	$ 8,000	1
2					2
3	TOTALS	6,969,600 SQ FT		$ 8,000	3

Facility Name & ID Number Mount St Joseph # 0005520 Report Period Beginning: 07/01/09 Ending: 06/30/10

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	132		1969	1969	$ 5,007,009	$ 392,511		$ 392,511	$	$ 7,989,803	4
5											5
6			1990	1990	2,361,653	78,720		78,720		1,613,762	6
7			1990	1990	68,729	2,289		2,289		46,945	7
8											8
	Improvement Type**										
9	LAND DEVELOPMENTAL-PRIOR YEARS ;			1993	29,005						9
10				1994	93,489						10
11				1995	44,713						11
12				1996	18,082						12
13				1997	42,570						13
14				1998	17,423						14
15				1999	21,853						15
16				2001	4,700						16
17				2005	22,748						17
18				2006	12,917						18
19											19
20	BUILDING IMPROVEMENTS-PRIOR YEARS:			1991	74,205						20
21				1992	90,293						21
22				1993	180,181						22
23				1994	178,251						23
24				1995	231,228						24
25				1996	82,875						25
26				1997	71,814						26
27				1998	116,448						27
28				1999	121,823						28
29				2000	37,015						29
30				2001	76,812						30
31				2002	112,086						31
32				2003	250,123						32
33				2004	402,099						33
34				2005	802,449						34
35				2006	1,003,267						35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Mount St Joseph # 0005520 Report Period Beginning: 07/01/09 Ending: 06/30/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	LAND IMPROVEMENTS		$	$		$	$	$	37
38	PAVEMENT REPAIR	2007	33,000						38
39	TREE REMOVAL	2007	2,000						39
40	CHAIN LINK FENCE	2007	47,454						40
41	LANDSCAPING	2008	23,887						41
42	PAVING	2008	59,000						42
43	PAVING	2008	59,000						43
44	LANDSCAPING	2008	5,200						44
45	TREE REMOVAL	2008	9,425						45
46	CEMETERY MEMORIALS	2009	3,409						46
47	STUMP REMOVAL	2009	3,500						47
48	TREE REMOVAL	2009	2,850						48
49	PAVING	2009	148,000						49
50									50
51									51
52	BUILDING IMPROVEMENTS								52
53	THERAPY-TILE,PAINT,WALLPAPER	2007	203,276						53
54	DRYSYSTEM-REPAIR	2007	4,164						54
55	FIREALARM-PANEL	2007	16,900						55
56	ST.ALS-TUB INSTALLATION	2007	34,983						56
57	ADMINISTRATION-PHONE SYSTEM	2007	8,959						57
58	GYM-DRAPES	2007	12,525						58
59	AIR COMPRESSOR-SPRINKLER	2007	4,924						59
60	ADMINISTRATION-TOILET PARTITIONS	2007	7,800						60
61	TV ROOM-CABINRTS	2007	17,900						61
62	ANGEL GUARDIAN-HOT WATER TANK	2007	10,200						62
63	ABOVE GROUND POOL	2007	20,565						63
64	ADMINISTRATION-PAINT & WALLPAPER	2007	23,712						64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 12,338,493	$ 473,520		$ 473,520	$	$ 9,650,510	70

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

Facility Name & ID Number Mount St Joseph # 0005520 Report Period Beginning: 07/01/09 Ending: 06/30/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 12,338,493	$ 473,520		$ 473,520	$	$ 9,650,510	1
2	BUILDING IMPROVEMENTS								2
3									3
4	ADMINISTRATION DRAIN PIPE	2007	80,260						4
5	NEW BUILDING ELECTRICAL	2007	28,523						5
6	THERAPY SKYLIGHTS	2007	6,500						6
7	POOL NEW DECK	2007	22,974						7
8	THERAPY RR7 AIR SPA	2007	31,858						8
9	ADMINISTRATION PHONE SYSTEM	2007	26,239						9
10	THERAPY REST ROOM TILE & PLUMBING	2007	94,209						10
11	ADMINISTRATION RELOCATE GAS MAIN	2007	3,559						11
12	ST. MARYS HEAT CONTROL	2007	3,638						12
13	STORAGE TANK PIPING	2007	18,408						13
14	THERAPY 2 TUBS & LIFTS	2007	4,070						14
15	THERAPY TUB ROOM Cabinets	2007	13,400						15
16	THERAPY R47 AIR SPA	2008	117,087						16
17	KITCHEN SPRINKLER EQUIPMENT	2008	12,500						17
18	ADMINISTRATION FIRE PROTECTION TANK	2008	30,470						18
19	KITCHEN HOOD	2008	11,233						19
20	ADMINISTRATION UNDERGROUND SPRINKLER	2008	6,298						20
21	ADMINISTRATION 2 MAN HOLES	2008	7,700						21
22	NEW BUILDING TILE, PAINT, & WALLPAPER	2008	8,856						22
23	ADMINISTRATION REST ROOM TILE & PLUMBING	2008	60,935						23
24	ADMINISTRATION CLEANED BOILERS	2008	3,194						24
25	ADMINISTRATION REROUTE WATER LINE	2008	5,325						25
26	THERAPY CAT WALK 2 HR RATED DOORS	2008	2,691						26
27	KITCHEN KETTLE & OVEN	2008	36,527						27
28	NEW BUILDING FLOORING, WINDOWS, & PAINT	2008	150,000						28
29	KITCHEN 4 STAINLESS STEEL TABLES	2008	2,824						29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 13,127,771	$ 473,520		$ 473,520	$	$ 9,650,510	34

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

Facility Name & ID Number Mount St Joseph # 0005520 Report Period Beginning: 07/01/09 Ending: 06/30/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 13,127,771	$ 473,520		$ 473,520	$	$ 9,650,510	1
2	PUMPHOUSE RELOCATE POWER	2009	10,458						2
3	KITCHEN GAS METER & WATER PUMP REPAIR	2009	8,290						3
4	ATTIC ALUMINUM DOOR	2009	2,372						4
5	LIVINGROOM 2 CHANDLIERS	2009	2,024						5
6	WATERMAIN GLASS INSULLATION	2008	4,334						6
7	ADMINISTRATION CARPET	2008	16,225						7
8	KITCHEN SURFACE TOPS	2008	51,967						8
9	GYM CONDENSATE TANK	2008	5,381						9
10	NEW BUILDING 32 COPPER LIGHTS	2008	4,370						10
11	KITCHEN HOOD REPLACEMENT	2008	11,233						11
12	THERAPY 200 GAL WATER TANK	2008	5,134						12
13	NEW BUILDING PLUMBING & ELECTRICAL	2008	151,389						13
14	THERAPY HOT WATER HEATER	2008	17,529						14
15	KITCHEN TILE WORK	2008	50,940						15
16	KITCHEN HOOD REPLACEMENT	2008	11,574						16
17	KITCHEN REMOVE HALLWAY WINDOWS	2008	2,500						17
18	KITCHEN WALL COVERINGS	2008	9,800						18
19	GYM CONCRETE STOOP	2008	9,503						19
20	KITCHEN SEPTIC TANK	2008	13,090						20
21	NEW BUILDING FLOOR COVERINGS	2008	180,000						21
22	BOILERS DRAIN & FLUSH	2008	3,526						22
23	KITCHEN REROUTE RADIATOR	2008	5,321						23
24	THERAPY WINDOW CAULKING	2008	4,100						24
25	NEW BUILDING PLUMBING & ELECTRICAL	2008	398,823						25
26	JET AIR SPA	2008	84,032						26
27	NEW BUILDING	2008	398,824						27
28	CEILING LIFT SYSTEM	2008	239,024						28
29	KITCHEN ROOF	2008	37,473						29
30	KITCHEN CATCH BASIN	2008	2,989						30
31	FIRE PROTECTION SYSTEM	2008	34,858						31
32	MEDICINE ROOM SINK	2008	10,566						32
33									33
34	TOTAL (lines 1 thru 33)		$ 14,915,420	$ 473,520		$ 473,520	$	$ 9,650,510	34

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

Facility Name & ID Number Mount St Joseph # 0005520 Report Period Beginning: 07/01/09 Ending: 06/30/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 14,915,420	$ 473,520		$ 473,520	$	$ 9,650,510	1
2	DRY SYSTEM CLEANING	2009	6,804						2
3	KITCHEN FOUNDATION REPAIR	2009	28,390						3
4	ATTIC ELECTRIC HEATERS	2009	8,290						4
5	WINDOW TREATMENTS & DRAPES	2009	26,180						5
6	PASSAGEWAY HEATER & TUCK POINTING	2009	26,760						6
7	POOL ROOM PAINT	2009	15,490						7
8	FIRE ALARM PANEL	2009	19,000						8
9	GAS VALVES & PUMP	2009	17,785						9
10	DRAIN TILE SERVICES	2009	11,844						10
11	THERAPY COMPRESSOR	2009	11,262						11
12	MARCELLINA HALL REMOVE FIRE ALARM	2009	54,720						12
13	ST. ROSE ROOF	2009	26,815						13
14	FIRE ALARM - ST ALOYSIU	2009	41,200						14
15	PEWS FOR CHAPEL	2009	10,225						15
16	DOOR LOCKS AND RELATED	2009	11,425						16
17	RANE BATHING SYSTEM REC	2009	9,800						17
18	WINDOW DRAPERIES & HARD	2009	5,938						18
19	SMT HEALTH SYSTEMS FULL	2010	13,992						19
20	ANGEL GUARDIAN FLOOR TI	2010	6,985						20
21	NEW FIRE ALARM FOR ST J	2010	36,000						21
22	SMT HEALTH SYSTEM FULL	2010	6,990						22
23	Heat Exchanger for Admin Bldg	2010	8,960						23
24	Fire Alarm System Laundry	2010	17,000						24
25	Fire Alarm System - Chapel	2010	18,000						25
26	Passageway Remodel (Contracted Total)	2010	1,400,592						26
27	Admin Building Roof	2010	39,740						27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 16,795,606	$ 473,520		$ 473,520	$	$ 9,650,510	34

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

Facility Name & ID Number Mount St Joseph # 0005520 Report Period Beginning: 07/01/09 Ending: 06/30/10

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,550,686	$ 43,077	$ 43,077	$		$ 1,280,579	71
72	Current Year Purchases	14,969						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,565,655	$ 43,077	$ 43,077	$		$ 1,280,579	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	RESIDENT TRANSPORT	2002 FORD VAN	2002	$ 23,334	$ 2,333	$ 2,333	$		$ 19,251	76
77										77
78										78
79										79
80	TOTALS			$ 23,334	$ 2,333	$ 2,333	$		$ 19,251	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)	$ 18,392,595	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 518,930	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 518,930	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)	$ 10,950,340	85	

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	FARM EQUIPMENT	$ 40,316	$	$ 40,316	86
87	VEHICLES	321,304	29,651	184,893	87
88	NON-CARE	1,052,810	14,967	1,015,307	88
89					89
90					90
91	TOTALS	$ 1,414,430	$ 44,618	$ 1,240,516	91

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Mount St Joseph # 0005520 Report Period Beginning: 07/01/09 Ending: 06/30/10

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

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

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: *

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.	/2011	$ 10,891
13.	/2012	$
14.	/2013	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO
16. Rental Amount for movable equipment: $ 10,891 Description: Copy Machine
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number Mount St Joseph # 0005520 Report Period Beginning: 07/01/09 Ending: 06/30/10

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM	X
IN OTHER FACILITY	
COMMUNITY COLLEGE	
HOURS PER CNA	40

3. CLINICAL PORTION:

IN-HOUSE PROGRAM	X
IN OTHER FACILITY	
HOURS PER CNA	80

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)		2,000		2,000
4	Clinical Wages (b)		4,000		4,000
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$ 6,000	$	$ 6,000
10	SUM OF line 9, col. 1 and 2 (e)	$ 6,000			

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	5
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	5

(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.

Facility Name & ID Number Mount St Joseph # 0005520 Report Period Beginning: 07/01/09 Ending: 06/30/10

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care	L9 C1	visits	20,000					20,000	5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$ 20,000		$	$		$ 20,000	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.

STATE OF ILLINOIS

Facility Name & ID Number Mount St Joseph **#** 0005520 **Report Period Beginning:** 07/01/09 **Ending:** 06/30/10

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/10 **(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	$ 2,198,133	$ 2,198,133	1
2	Cash-Patient Deposits	101,842	101,842	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,146,989	1,146,989	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	146,594	146,594	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,593,558	$ 3,593,558	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	118,359	118,359	12
13	Land		8,000	13
14	Buildings, at Historical Cost		7,437,391	14
15	Leasehold Improvements, at Historical Cost	6,838,492	10,932,335	15
16	Equipment, at Historical Cost		3,003,419	16
17	Accumulated Depreciation (book methods)		(10,968,717)	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)**	$ 6,956,851	$ 10,530,787	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 10,550,409	$ 14,124,345	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 476,854	$ 476,854	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	101,842	101,842	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	279,969	279,969	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 858,665	$ 858,665	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 858,665	$ 858,665	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 9,691,744	$ 13,265,680	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 10,550,409	$ 14,124,345	48

***(See instructions.)**

Facility Name & ID Number Mount St Joseph # 0005520 **Report Period Beginning:** 07/01/09 **Ending:** 06/30/10

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 8,174,789	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 8,174,789	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,516,955	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 1,516,955	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)**	$ 9,691,744	24 *

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

Facility Name & ID Number Mount St Joseph # 0005520 Report Period Beginning: 07/01/09 Ending: 06/30/10

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

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,897,937	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,897,937	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions	875,401	24
25	Interest and Other Investment Income***	19,775	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 895,176	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28			28
28a	**DEVELOPMENTAL DAY TRAINING**	590,870	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 590,870	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,383,983	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,158,754	31
32	Health Care	2,733,407	32
33	General Administration	979,276	33
	B. Capital Expense		
34	Ownership	673,431	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	322,160	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,867,028	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,516,955	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,516,955	43

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

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

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

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

Facility Name & ID Number Mount St Joseph # 0005520 Report Period Beginning: 07/01/09 Ending: 06/30/10

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	17,197	18,063	$ 422,489	$ 23.39	1
2	Assistant Director of Nursing	2,554	2,682	51,929	19.36	2
3	Registered Nurses	2,050	2,154	18,306	8.50	3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	619	651	10,865	16.69	8
9	Activity Director	2,699	2,835	50,837	17.93	9
10	Activity Assistants					10
11	Social Service Workers	832	874	16,857	19.29	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	10,556	11,087	111,090	10.02	15
16	Dishwashers					16
17	Maintenance Workers	14,408	15,133	241,520	15.96	17
18	Housekeepers	38,999	40,962	344,900	8.42	18
19	Laundry	4,977	5,228	41,768	7.99	19
20	Administrator	3,503	3,679	57,947	15.75	20
21	Assistant Administrator	3,726	3,913	45,000	11.50	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,254	10,770	163,816	15.21	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director	1,088	1,143	20,000	17.50	27
28	Qualified MR Prof. (QMRP)	8,065	8,471	147,568	17.42	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	123,266	129,471	1,299,886	10.04	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) DAY TRAINING	23,448	24,628	263,768	10.71	33
34	TOTAL (lines 1 - 33)	268,241	281,744	$ 3,308,546 *	$ 11.74	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	147	$ 7,349	L 1 C 3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	107	8,043	L 10 C 3	45
46	Other(specify) DENTIST	72	3,588	L 10 C 3	46
47	PSYCHIATRIST	16	4,000	L 12 C 3	47
48	PODIATRIST	26	1,530	L 10 C 3	48
49	TOTAL (lines 35 - 48)	368	$ 24,510		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Mount St Joseph # 0005520 Report Period Beginning: 07/01/09 Ending: 06/30/10

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
GERTRUDE LABARBERA	SUPERIOR		$ 58,500
MARY WALKER	ADMINISTRATOR		29,250
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 87,750

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
B.I.K. & CO.	AUDITORS	$ 34,045
MICHAEL SULLIVAN	ACCOUNTING	32,225
AMCHECK	PAYROLL	14,981
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 81,251

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 139,449
Unemployment Compensation Insurance	0
FICA Taxes	245,818
Employee Health Insurance	6,955
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
Employee Pensioin	108,186
Day Training Payroll Tax	(28,688)
TOTAL (agree to Schedule V, line 22, col.8)	$ 471,720

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 5,000
Advertising: Employee Recruitment	0
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
Licenses & Fees	19,242
Dues & Subs	3,386
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 27,628

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	110
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 110

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Mount St Joseph # 0005520 Report Period Beginning: 07/01/09 Ending: 06/30/10

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	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Mount St Joseph # 0005520 **Report Period Beginning:** 07/01/09 **Ending:** 06/30/10

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **NO**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YRS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **10,191** Line **L6**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **322,160**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **YES** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **YES** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **100**
c. What percent of all travel expense relates to transportation of nurses and patients? **10%**
d. Have vehicle usage logs been maintained? **YES**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? YES
Indicate the amount of income earned from providing such transportation during this reporting period. $ **0**

(17) Has an audit been performed by an independent certified public accounting firm? **YES**
Firm Name: **B.I.K. & CO.**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees

V. ADJUSTMENT DETAIL/UTILITIES	PAGE 5	SQUARE FOOTAGE
CARE RELATED AREAS;		
THERAPEUTIC CENTER		22,122
JOSEPH,S		9,464
OLD NURSES STATION TO KITCHEN PASSAGEWAY		6,770
PASSAGEWAY		6,947
ADMINISTRATIVE BUILDING		6,890
ST. ALIYIOUS		9,270
NOVITIATE & AUDITORIUM		11,120
GUANELLA		15,887
ANGEL GUARDIAN		9,582
KITCHEN		5,749
BOILER & LAUNDRY		4,690
GARAGE		660
CHAPEL		12,468
CHAPLAIN.S HOUSE		4,022
GARAGE		1,012
ADMON BUILDING 2nd FLOOR		3,445
ST. MARY,S		11,691
ST. CLAIR.S		19,014
	TOTAL..	160,803
NON-CARE RELATED AREAS:		
NOVITIATE & AUDITORIUM		5,560
FARM HOUSE		1,768
	TOTAL	7,328
TOTAL SQUARE FOOTAGE		168,131
NON-CARE AREAS	7,328/168,131	4%
TOTAL UTILITIES LINE 5 PAGE 3		217,577
		4.0%
TOTAL NON-CARE RELATED UTILITIES - L5 C7 schedule V - page 3		8,703