

Facility Name & ID Number St Joseph's Home For The Elderly

0027045 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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 N/A

	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	20	Skilled (SNF)	20	7,300	1
2		Skilled Pediatric (SNF/PED)			2
3	40	Intermediate (ICF)	40	14,600	3
4		Intermediate/DD			4
5	7	Sheltered Care (SC)	7	2,555	5
6		ICF/DD 16 or Less			6
7	67	TOTALS	67	24,455	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total
		3 Medicaid Recipient	4 Private Pay	Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	18,946	1,924		20,870	10
11	ICF/DD					11
12	SC		2,384		2,384	12
13	DD 16 OR LESS					13
14	TOTALS	18,946	4,308		23,254	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.79%

D. How many bed-hold days during this year were paid by the Department? 63 (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 01/09/1967

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

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

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2010 Fiscal Year: 12/31/2010

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

Facility Name & ID Number St Joseph's Home For The Elderly # 0027045 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	353,413	6,934	84,373	444,720		444,720	(60,268)	384,452		1
2	Food Purchase		93,621		93,621		93,621		93,621		2
3	Housekeeping		22,396	225,484	247,880		247,880		247,880		3
4	Laundry	74,163	18,443	17,757	110,363		110,363	(6,677)	103,686		4
5	Heat and Other Utilities			329,024	329,024		329,024	(131,053)	197,971		5
6	Maintenance	156,448	92,283	168,018	416,749		416,749	(29,382)	387,367		6
7	Other (specify):*	62,120		11,380	73,500		73,500		73,500		7
8	TOTAL General Services	646,144	233,677	836,036	1,715,857		1,715,857	(227,380)	1,488,477		8
	B. Health Care and Programs										
9	Medical Director			2,400	2,400		2,400		2,400		9
10	Nursing and Medical Records	1,835,494	64,790	130,787	2,031,071		2,031,071		2,031,071		10
10a	Therapy	73,345			73,345		73,345		73,345		10a
11	Activities	101,573	10,074	1,624	113,271		113,271		113,271		11
12	Social Services	23,223		800	24,023		24,023		24,023		12
13	CNA Training										13
14	Program Transportation			3,419	3,419		3,419		3,419		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,033,635	74,864	139,030	2,247,529		2,247,529		2,247,529		16
	C. General Administration										
17	Administrative			81,419	81,419		81,419		81,419		17
18	Directors Fees										18
19	Professional Services			70,728	70,728		70,728		70,728		19
20	Dues, Fees, Subscriptions & Promotions			60,493	60,493		60,493	(44,234)	16,259		20
21	Clerical & General Office Expenses	261,060	43,504	173,810	478,374		478,374		478,374		21
22	Employee Benefits & Payroll Taxes			619,390	619,390		619,390		619,390		22
23	Inservice Training & Education			7,895	7,895		7,895		7,895		23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation			10,258	10,258		10,258		10,258		25
26	Insurance-Prop.Liab.Malpractice			42,624	42,624		42,624	(6,858)	35,766		26
27	Other (specify):* Bad Debts			67,109	67,109		67,109	(67,109)			27
28	TOTAL General Administration	261,060	43,504	1,133,726	1,438,290		1,438,290	(118,201)	1,320,089		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,940,839	352,045	2,108,792	5,401,676		5,401,676	(345,581)	5,056,095		29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			395,105	395,105		395,105	(51,452)	343,653			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			395,105	395,105		395,105	(51,452)	343,653			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		121		121		121		121			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			32,850	32,850		32,850		32,850			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		121	32,850	32,971		32,971		32,971			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,940,839	352,166	2,536,747	5,829,752		5,829,752	(397,033)	5,432,719			45

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

St Joseph's Home For The Elderly

ID# 0027045

Report Period Beginning: 01/01/2010

Ending: 12/31/2010

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
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			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	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number St Joseph's Home For The Elderly# 0027045

Report Period Beginning:

01/01/2010

Ending:

12/31/2010

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	(60,268)	0	0	0	0	0	0	0	0	0	0	(60,268)	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	(6,677)	0	0	0	0	0	0	0	0	0	0	(6,677)	4
5	Heat and Other Utilities	(131,053)	0	0	0	0	0	0	0	0	0	0	(131,053)	5
6	Maintenance	(29,382)	0	0	0	0	0	0	0	0	0	0	(29,382)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(227,380)	0	0	0	0	0	0	0	0	0	0	(227,380)	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	(44,234)	0	0	0	0	0	0	0	0	0	0	(44,234)	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	(6,858)	0	0	0	0	0	0	0	0	0	0	(6,858)	26
27	Other (specify):*	(67,109)	0	0	0	0	0	0	0	0	0	0	(67,109)	27
28	TOTAL General Administration	(118,201)	0	0	0	0	0	0	0	0	0	0	(118,201)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(345,581)	0	0	0	0	0	0	0	0	0	0	(345,581)	29

STATE OF ILLINOIS

Facility Name & ID Number St Joseph's Home For The Elderly# 0027045

Report Period Beginning:

01/01/2010 Ending:

Summary B

12/31/2010

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	(51,452)	0	0	0	0	0	0	0	0	0	0	(51,452)	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	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	(51,452)	0	0	0	0	0	0	0	0	0	0	(51,452)	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)	(397,033)	0	0	0	0	0	0	0	0	0	0	(397,033)	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		Little Sisters of the Poor -		Little Sisters of the Poor - Chicago		
		St. Mary's Home	Chicago, IL	Province, Inc.	Palatine, IL	Religious Order

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	19 Payroll Processing	\$ 19,358	Little Sisters of the Poor - Chicago Province, Inc.	0.00%	\$ 19,358	\$	1
2	V	19 Corporate Compliance	6,815	Little Sisters of the Poor - Chicago Province, Inc.	0.00%	6,815		2
3	V	19 Computer Consulting - IT	8,508	Little Sisters of the Poor - Chicago Province, Inc.	0.00%	8,508		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		\$ 34,681			\$ 34,681	\$ *	14

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

Facility Name & ID Number St Joseph's Home For The Elderly # 0027045 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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											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's Home For The Elderly # 0027045 Report Period Beginning: 01/01/2010 Ending: 2/31/2010

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									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's Home For The Elderly

0027045

Report Period Beginning:

01/01/2010

Ending:

12/31/2010

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										
										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	Little Sisters of the Poor									1									
2	- Chicago Province, Inc.	X		Construction	NONE	Various	1,258,650	1,258,650	Various	0.0300	2								
3											3								
4											4								
5											5								
Working Capital																			
6	Little Sisters of the Poor										6								
7	- Chicago Province, Inc.	X		Working Capital	NONE	Various	2,685,120	2,685,120	Various	0.0300	7								
8											8								
9	TOTAL Facility Related						\$ 3,943,770	\$ 3,943,770			9								
B. Non-Facility Related*																			
10	Little Sisters of the Poor										10								
11	- Chicago Province, Inc.	X		Convent Allocation	NONE	Various	756,230	756,230	Various	0.0300	11								
12											12								
13											13								
14	TOTAL Non-Facility Related						\$ 756,230	\$ 756,230			14								
15	TOTALS (line 9+line14)						\$ 4,700,000	\$ 4,700,000			15								

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

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

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

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

B. Real Estate Taxes

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

1. Real Estate Tax accrual used on 2009 report.		\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	2
3. Under or (over) accrual (line 2 minus line 1).		\$	3
4. Real Estate Tax accrual used for 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.)		\$	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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2009 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 2009 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2009.

Please complete the Real Estate Tax Statement below and include it in the 2010 cost report along with a copy of your 2009 real estate tax bill.

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.

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME St Joseph's Home For The Elderly COUNTY Cook
 FACILITY IDPH LICENSE NUMBER 0027045
 CONTACT PERSON REGARDING THIS REPORT Mother Marguerite McCarthy
 TELEPHONE (847) 358-5700 FAX #: (847) 358-5719

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)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>N/A</u>	<u>_____</u>	\$ <u>_____</u>	\$ <u>_____</u>
2. <u>_____</u>	<u>_____</u>	\$ <u>_____</u>	\$ <u>_____</u>
3. <u>_____</u>	<u>_____</u>	\$ <u>_____</u>	\$ <u>_____</u>
4. <u>_____</u>	<u>_____</u>	\$ <u>_____</u>	\$ <u>_____</u>
5. <u>_____</u>	<u>_____</u>	\$ <u>_____</u>	\$ <u>_____</u>
6. <u>_____</u>	<u>_____</u>	\$ <u>_____</u>	\$ <u>_____</u>
7. <u>_____</u>	<u>_____</u>	\$ <u>_____</u>	\$ <u>_____</u>
8. <u>_____</u>	<u>_____</u>	\$ <u>_____</u>	\$ <u>_____</u>
9. <u>_____</u>	<u>_____</u>	\$ <u>_____</u>	\$ <u>_____</u>
10. <u>_____</u>	<u>_____</u>	\$ <u>_____</u>	\$ <u>_____</u>
TOTALS		\$ <u>=====</u>	\$ <u>=====</u>

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 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 St Joseph's Home For The Elderly

0027045

Report Period Beginning:

01/01/2010 Ending:

12/31/2010

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 119,979 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 3

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).

34 APTS. INDEPENDENT LIVING FACILITIES - NOT a separate entity. Facility is NOT run as a business, but is a part of the mission of the Little Sisters of the Poor - taking care of the elderly poor. See page 23A for additional information. Expenses for the apartments are NOT included in this cost report.

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: N/A 2. Number of Years Over Which it is Being Amortized: N/A
 3. Current Period Amortization: N/A 4. Dates Incurred: N/A

Nature of Costs: N/A
 (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>Existing Structure</u>	<u>653,400</u>	<u>1966</u>	<u>\$ 76,284</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	653,400		\$ 76,284	3

Facility Name & ID Number St Joseph's Home For The Elderly

0027045

Report Period Beginning:

01/01/2010 Ending:

12/31/2010

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	67		1966	1966	\$ 3,221,573	\$	40	\$	\$	\$ 3,221,573	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		Health Related Renovation	1967		24,177		40			24,177	9
10		Health Related Renovation	1968		34,542		40			34,542	10
11		Health Related Renovation	1969		26,308	313	40		(313)	26,308	11
12		Health Related Renovation	1970		40,716	1,213	40	353	(860)	40,716	12
13		Health Related Renovation	1971		22,307	665	40	558	(107)	21,985	13
14		Health Related Renovation	1972		119,419	3,558	40	2,986	(572)	116,427	14
15		Health Related Renovation	1974		10,272	306	40	257	(49)	9,588	15
16		Health Related Renovation	1975		9,671	288	40	242	(46)	8,833	16
17		Health Related Renovation	1976		965	29	40	24	(5)	859	17
18		Health Related Renovation	1978		44,279	1,319	40	1,107	(212)	37,209	18
19		Interior Renovation - Conversion from Wards to Rooms	1983		3,663,633	109,154	40	91,591	(17,563)	2,585,234	19
20		New Fire Door System	1984		25,217	751	40	630	(121)	16,946	20
21		Complete Boiler Renovation	1985		470,291	14,012	40	11,757	(2,255)	303,960	21
22		Electrical Repairs & New Cooling System for Boilers	1987		106,618	3,177	40	2,666	(511)	63,393	22
23		Concrete Restoration	1990		111,172	3,312	40	2,779	(533)	57,536	23
24		Exterior Renovation Including New Windows	1991		317,750	9,467	40	7,944	(1,523)	156,168	24
25		Driveway Restored	1991		32,334		10			32,334	25
26		Sewer Renovation	1992		13,999	417	40	350	(67)	6,508	26
27		Asbestos Removal & Central Air Conditioning	1992		1,051,235	31,320	40	26,281	(5,039)	498,216	27
28		Remodel Center & West Wings	1993		2,619,173	78,035	40	65,479	(12,556)	1,140,307	28
29		Pond Dredge	1995		24,711		14			24,711	29
30		Back Driveway Replaced	1996		57,358		10			57,358	30
31		Patio and Sidewalk Restoration	1998		27,055		10			27,055	31
32		Asphalt Paving	1998		1,888		10			1,888	32
33		Front Walkway Lighting Restoration	1998		2,892		10			2,892	33
34		Brick Paving, Concrete and Electric for Front Walkway/Sitting Area	2000		11,634	693	10	585	(108)	11,634	34
35		Evergreens, Statue and Pedestal	2003		6,168	368	20	309	(59)	2,313	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	Handicap Switches to Front Door	2004	\$ 1,326	\$ 40	40	\$ 34	\$ (6)	\$ 189	37
38	New Flooring	2006	1,339	40	40	34	(6)	152	38
39	Asphalt Replacement	2008	7,063	842	10	706	(136)	1,765	39
40	Garage Roof	2009	13,039	388	40	326	(62)	489	40
41	Parking Lot Lights and Poles	2009	35,825	2,135	20	1,791	(344)	2,687	41
42	Concrete and Curb Replacement	2009	15,752	1,877	10	1,575	(302)	2,363	42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50	2006 Cap Bldg Repairs - Elevator Motor Repair	2006	2,916		5	583	583	2,624	50
51	2007 Cap Bldg Repairs - Roof and Electrical Repairs	2007	17,788		5	3,558	3,558	12,453	51
52	2008 Cap Bldg Repairs - Storm Sewer Repair	2008	3,067		5	613	613	1,533	52
53	2009 Cap Bldg Repairs - Doors, Fire Alarm, HVAC and Plumbing	2009	29,121		5	5,824	5,824	8,736	53
54	2010 Cap Bldg Repairs - HVAC, Plumbing and Electric Repairs	2010	24,655		5	2,466	2,466	2,466	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)		\$ 12,249,248	\$ 263,719		\$ 233,408	\$ (30,311)	\$ 8,566,127	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	\$	\$	\$	\$		\$	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$	\$	\$	\$		\$	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	Care Use	1989 M/F Diesel Tractor	1989	\$ 21,817	\$	\$	\$	4	\$ 21,817	76
77	Care Use	1994 Lewis Riding Mower	1994	5,807				4	5,807	77
78	Care Use	1998 Steer-Rite Pallet Truck	1998	470				4	470	78
79	Care Use	1996 Great Chariot Mower	1999	6,521				4	6,521	79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1	2	
	Reference	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)	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	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)	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		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	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.

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	\$	\$	\$	\$		\$	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$	\$	\$	\$		\$	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	Care Use	1996 Pontiac Grand Prix	2002	\$ 6,168	\$	\$	\$	4	\$ 6,168	76
77	Care Use	2004 Ford Taurus	2004	17,647				4	17,647	77
78	Care Use	2005 John Deere 757 Mower	2005	6,312				4	6,312	78
79	Care Use	2005 Ford E450 Bus	2005	47,077				4	47,077	79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1	2	
	Reference	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)	\$
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$

**

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		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	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.

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	\$ 904,169	\$ 107,356	\$ 90,082	\$ (17,274)	10 Years	\$ 429,540	71
72	Current Year Purchases	77,312	5,931	4,977	(954)	10 Years	4,977	72
73	Fully Depreciated Assets	706,442				10 Years	706,442	73
74								74
75	TOTALS	\$ 1,687,923	\$ 113,287	\$ 95,059	\$ (18,228)		\$ 1,140,959	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	Care Use	2006 Chrysler Town & Country	2006	\$ 18,627	\$ 2,775	\$ 2,328	\$ (447)	4	\$ 18,627	76
77	Care Use	2008 Ford E350 Van	2007	25,605	7,629	6,401	(1,228)	4	22,404	77
78	Care Use	2008 Ford F250 Truck w/Plow	2007	25,829	7,695	6,457	(1,238)	4	22,599	78
79										79
80	TOTALS			\$ 181,880	\$ 18,099	\$ 15,186	\$ (2,913)		\$ 175,449	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)	\$ 14,195,335	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 395,105	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 343,653	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (51,452)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 9,882,535	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	Bldg - Convent Allocation Various	\$ 2,333,961	\$ 43,355	\$ 1,568,929	86
87	Equip - Convent Allocation Various	323,665	18,228	218,780	87
88	Vehicles - Convent Allocation Var	34,876	2,913	33,645	88
89					89
90					90
91	TOTALS	\$ 2,692,502	\$ 64,496	\$ 1,821,354	91

G. Construction-in-Progress

	Description	Cost	
92	Roof Re-Surfacing	\$ 340,809	92
93			93
94			94
95		\$ 340,809	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: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions. YES NO

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

8. List separately any amortization of lease expense included on page 4, line 34. _____

This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

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

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

15. Is Movable equipment rental included in building rental? _____

YES NO

16. Rental Amount for movable equipment: \$ _____ Description: _____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /2011 \$ _____

13. _____ /2012 \$ _____

14. _____ /2013 \$ _____

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

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

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" 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>* ALL AIDES EMPLOYED HAVE PREVIOUSLY OBTAINED THE NECESSARY TRAINING</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
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.

\$

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	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		visits							5
6	Dental Care	39-2	visits				121		121	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$		\$	121		\$ 121	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's Home For The Elderly# 0027045Report Period Beginning: 01/01/2010Ending: 12/31/2010

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2010

(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	\$ 815,465	\$	1
2	Cash-Patient Deposits	25,365		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>15,000</u>)	177,758		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	20,307		6
7	Other Prepaid Expenses	8,664		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,047,559	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments	168,265		12
13	Land	111,387		13
14	Buildings, at Historical Cost	14,505,662		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,228,344		16
17	Accumulated Depreciation (book methods)	(11,676,077)		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): <u>Construction in Progress</u>	340,809		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 5,678,390	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,725,949	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 209,438	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	25,365		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	116,474		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)	\$ 351,277	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	4,700,000		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)	\$ 4,700,000	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,051,277	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,674,672	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,725,949	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,879,450	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,879,450	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,204,778)	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)	\$ (1,204,778)	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)	\$ 1,674,672	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number St Joseph's Home For The Elderly

0027045

Report Period Beginning: 01/01/2010

Ending: 12/31/2010

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	\$ 2,619,240	1
2	Discounts and Allowances for all Levels	(152,931)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,466,309	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	2,079,658	24
25	Interest and Other Investment Income***	79,007	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,158,665	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,624,974	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,715,857	31
32	Health Care	2,247,529	32
33	General Administration	1,438,290	33
B. Capital Expense			
34	Ownership	395,105	34
C. Ancillary Expense			
35	Special Cost Centers	121	35
36	Provider Participation Fee	32,850	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,829,752	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,204,778)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,204,778)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? NO 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's Home For The Elderly

0027045

Report Period Beginning: 01/01/2010

Ending: 12/31/2010

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing				1	
2	Assistant Director of Nursing	1,879	2,271	73,066	32.17	2
3	Registered Nurses	18,132	20,461	571,363	27.92	3
4	Licensed Practical Nurses	9,354	11,422	277,083	24.26	4
5	CNAs & Orderlies	54,000	59,440	887,930	14.94	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,753	4,416	73,345	16.61	8
9	Activity Director	317	388	7,337	18.91	9
10	Activity Assistants	6,230	6,894	94,236	13.67	10
11	Social Service Workers	1,172	1,338	23,223	17.36	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	27,896	31,305	353,413	11.29	15
16	Dishwashers					16
17	Maintenance Workers	6,907	8,007	156,448	19.54	17
18	Housekeepers					18
19	Laundry	5,463	6,116	74,163	12.13	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,662	13,764	261,060	18.97	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,600	1,784	26,052	14.60	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Security Guards</u>	3,894	4,325	62,120	14.36	33
34	TOTAL (lines 1 - 33)	153,259	171,931	\$ 2,940,839 *	\$ 17.10	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	136	\$ 5,440	1-3	35
36	Medical Director	96	2,400	9-3	36
37	Medical Records Consultant	17	990	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	100	4,422	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	33	1,624	11-3	44
45	Social Service Consultant	16	800	12-3	45
46	Other(specify) <u>One Sister Acting</u>				46
47	<u>as Director of Nursing at Stipend +</u>				47
48	<u>Insurance - Room & Board</u>	2,080	39,677	10-3	48
49	TOTAL (lines 35 - 48)	2,478	\$ 55,353		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

Facility Name & ID Number St Joseph's Home For The Elderly# 0027045Report Period Beginning: 01/01/2010 Ending: 12/31/2010**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. N/A
- (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? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 12,784 Line 10
- (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. \$ 32,850
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. \$ 0 Has any meal income been offset against related costs? No Indicate the amount. \$ 0
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation. N/A
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? 25% for Acti
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? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Varey & Vaccariello CPAs PC
- (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.