		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: 0005637

Facility Name: ST JOSEPH NURSING HOME

Address: 401 9TH STREET (Number) LACON (City) 61540 (Zip Code)

County: MARSHALL

Telephone Number: (309) 246-2175 **Fax #** (309) 246-2299

HFS ID Number:

Date of Initial License for Current Owners: 1964

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: LARRY PEVNICK **Telephone Number:** (314) 983-1247
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 7/1/2009 to 6/30/2010 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) LISA HELMS
(Title) ADMINISTRATOR

Paid Preparer
(Signed) (Date)
(Print Name and Title) LARRY PEVNICK, MEMBER
(Firm Name & Address) BROWN SMITH WALLACE, L.L.C., 1050 NORTH LINDBERGH BLVD.
(Telephone) (314) 983-1200 Fax # (314) 983-1300

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 ST JOSEPH NURSING HOME # 0005637 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

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 93

	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)	16	5,840	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)	77	28,105	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7		TOTALS	93	33,945	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	927	1,310	3,013	5,250	8
9	SNF/PED					9
10	ICF	17,605	7,424	0	25,029	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,532	8,734	3,013	30,279	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.20%

D. How many bed-hold days during this year were paid by the Department?
NONE (Do not include bed-hold days in Section B.)

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 5/7/1965

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 93 and days of care provided 3,013

Medicare Intermediary NGS

IV. ACCOUNTING BASIS

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

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

Tax Year: 7/1/09 - 6/31/10 Fiscal Year: 7/1/09 - 6/31/10

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

Facility Name & ID Number ST JOSEPH NURSING HOME # 0005637 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

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	300,398		25,964	326,362		326,362	(31,942)	294,420			1
2	Food Purchase		231,437		231,437		231,437	(67,376)	164,061			2
3	Housekeeping	95,314	24,987		120,301		120,301	0	120,301			3
4	Laundry	117,700		3,375	121,075	0	121,075	0	121,075			4
5	Heat and Other Utilities			134,274	134,274		134,274	(4,964)	129,310			5
6	Maintenance	73,582		39,370	112,952		112,952	0	112,952			6
7	Other (specify):*				0		0	0	0			7
8	**TOTAL General Services**	586,994	256,424	202,983	1,046,401	0	1,046,401	(104,282)	942,119			8
	B. Health Care and Programs											
9	Medical Director				0		0	0	0			9
10	Nursing and Medical Records	2,072,942	128,214	4,738	2,205,894		2,205,894	0	2,205,894			10
10a	Therapy			384,380	384,380		384,380	0	384,380			10a
11	Activities	81,105	5,001	1,600	87,706		87,706	0	87,706			11
12	Social Services	78,674	218	2,550	81,442		81,442	0	81,442			12
13	CNA Training			803	803		803	0	803			13
14	Program Transportation				0		0	0	0			14
15	Other (specify):* **Bad Debt Expense**			143,552	143,552		143,552	(143,552)	0			15
16	**TOTAL Health Care and Programs**	2,232,721	133,433	537,623	2,903,777	0	2,903,777	(143,552)	2,760,225			16
	C. General Administration											
17	Administrative				0		0	0	0			17
18	Directors Fees				0		0	0	0			18
19	Professional Services			306,530	306,530		306,530	0	306,530			19
20	Dues, Fees, Subscriptions & Promotions			65,693	65,693		65,693	0	65,693			20
21	Clerical & General Office Expenses	131,785	12,164	43,242	187,191		187,191	(6,494)	180,697			21
22	Employee Benefits & Payroll Taxes			548,305	548,305		548,305	(5,462)	542,843			22
23	Inservice Training & Education				0		0	0	0			23
24	Travel and Seminar			9,653	9,653		9,653	0	9,653			24
25	Other Admin. Staff Transportation				0		0	0	0			25
26	Insurance-Prop.Liab.Malpractice			115,929	115,929		115,929	0	115,929			26
27	Other (specify):*				0		0	0	0			27
28	**TOTAL General Administration**	131,785	12,164	1,089,352	1,233,301	0	1,233,301	(11,956)	1,221,345			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,951,500	402,021	1,829,958	5,183,479	0	5,183,479	(259,790)	4,923,689			29

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

Facility Name & ID Number ST JOSEPH NURSING HOME #0005637 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

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			57,441	57,441		57,441	0	57,441			30
31	Amortization of Pre-Op. & Org.				0		0	0	0			31
32	Interest			19,463	19,463		19,463	(19,463)	0			32
33	Real Estate Taxes				0		0	0	0			33
34	Rent-Facility & Grounds				0		0	0	0			34
35	Rent-Equipment & Vehicles				0		0	0	0			35
36	Other (specify):*				0		0	0	0			36
37	TOTAL Ownership			76,904	76,904	0	76,904	(19,463)	57,441			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers			140,084	140,084		140,084	0	140,084			39
40	Barber and Beauty Shops			7,212	7,212		7,212	0	7,212			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee			42,455	42,455		42,455	0	42,455			42
43	Other (specify):*				0		0	0	0			43
44	TOTAL Special Cost Centers	0	0	189,751	189,751	0	189,751	0	189,751			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,951,500	402,021	2,096,613	5,450,134	0	5,450,134	(279,253)	5,170,881			45

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

Facility Name & ID Number ST JOSEPH NURSING HOME # 0005637 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

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				3
4	Non-Patient Meals	(20,234)	2		4
5	Telephone, TV & Radio in Resident Rooms	(6,494)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(19,463)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(24,491)	2		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(143,552)	15		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				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (214,234)		$ 0	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)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 0		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (214,234)		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

ST JOSEPH NURSING HOME

ID# 0005637

Report Period Beginning: 7/1/2009

Ending: 6/30/2010

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Sister's Portion of Dietary Costs	$ (31,942)	1	1
2	Sister's Portion of Food Costs	(22,651)	2	2
3	Sister's Portion of Heat and Other Utilities	(4,964)	5	3
4	Sister's Portion of Employee Benefits in Meals	(5,462)	22	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(65,019)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number ST JOSEPH NURSING HOME **#** 0005637 **Report Period Beginning:** 7/1/2009 **Ending:** 6/30/2010

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	(31,942)	0	0	0	0	0	0	0	0	0	0	(31,942)	1
2	Food Purchase	(67,376)	0	0	0	0	0	0	0	0	0	0	(67,376)	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	(4,964)	0	0	0	0	0	0	0	0	0	0	(4,964)	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**	(104,282)	0	0	0	0	0	0	0	0	0	0	(104,282)	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):*	(143,552)	0	0	0	0	0	0	0	0	0	0	(143,552)	15
16	**TOTAL Health Care and Programs**	(143,552)	0	0	0	0	0	0	0	0	0	0	(143,552)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(6,494)	0	0	0	0	0	0	0	0	0	0	(6,494)	21
22	Employee Benefits & Payroll Taxes	(5,462)	0	0	0	0	0	0	0	0	0	0	(5,462)	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**	(11,956)	0	0	0	0	0	0	0	0	0	0	(11,956)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(259,790)	0	0	0	0	0	0	0	0	0	0	(259,790)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number ST JOSEPH NURSING HOME # 0005637 **Report Period Beginning:** 7/1/2009 **Ending:** 6/30/2010

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	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(19,463)	0	0	0	0	0	0	0	0	0	0	(19,463)	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**	(19,463)	0	0	0	0	0	0	0	0	0	0	(19,463)	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)**	(279,253)	0	0	0	0	0	0	0	0	0	0	(279,253)	45

Facility Name & ID Number ST JOSEPH NURSING HOME # 0005637 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

VII. RELATED PARTIES

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

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

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

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

1 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			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

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

Facility Name & ID Number ST JOSEPH NURSING HOME # 0005637 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

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	THIS WORKSHEET IS NOT APPLICABLE.										2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

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

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

Facility Name & ID Number ST JOSEPH NURSING HOME # 0005637 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

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
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						$	$		$	1
2		THIS WORKSHEET IS NOT APPLICABLE.								2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number ST JOSEPH NURSING HOME # 0005637 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

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	
	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	Daughters of St. Francis of						$	$			$	1
2	Assisi (Motherhouse)	X		Working Capital	$1,000.00	Various	204,400	4,000	NONE	NONE		2
3	Bank of Lacon		X	Working Capital	$1,675.00	8/11/05	350,000	289,968	11/15/10	6.5000		3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$2,675.00		$ 554,400	$ 293,968			$ 0	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$ 0	$ 0			$ 0	14
15	TOTALS (line 9+line14)						$ 554,400	$ 293,968			$ 0	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 ST JOSEPH NURSING HOME # 0005637 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

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.**	$	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).		$ 0	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.		$ 0	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	2005	8
	2006	9
	2007	10
	2008	11
	2009	12

THIS WORKSHEET IS NOT APPLICABLE.

	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 ST JOSEPH NURSING HOME COUNTY MARSHALL

FACILITY IDPH LICENSE NUMBER 0005637

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 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.	THIS WORKSHEET IS NOT APPLICABLE.		$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 0.00	$ 0.00

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 NURSING HOME # 0005637 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 66,656 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories ONE

C. Does the Operating Entity? [X] (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? [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).

NOT APPLICABLE

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: NOT APPLICABLE
2. Number of Years Over Which it is Being Amortized: NOT APPLICABLE
3. Current Period Amortization: NOT APPLICABLE
4. Dates Incurred: NOT APPLICABLE

Nature of Costs:
(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	OWNED BY DAUGHTERS			$	1
2	OF ST. FRANCIS OF ASSISI	428,532	1965	25,700	2
3	TOTALS	428,532		$ 25,700	3

Facility Name & ID Number ST JOSEPH NURSING HOME # 0005637 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

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	43			1965	$ 484,023	$	VARIOUS	$	$	$ 484,023	4
5	50			1969	898,293		VARIOUS			898,293	5
6				1968	451,401		25			451,401	6
7				1986	9,717		12			9,717	7
8				2010	5,818	194	15	194		194	8
	Improvement Type**										
9	MISC			1968	6,160		50			6,160	9
10	GARAGE			1972	2,491		50			2,491	10
11	FINISH BASEMENT			1973	6,343		50			6,343	11
12	WINDOW			1974	900		50			900	12
13	INSULATION			1976	21,986		50			21,896	13
14	ROOF			1980	16,049		50			16,049	14
15	MISC REMODELING			1981	7,711		10			7,711	15
16	IDPA AUDIT ADJUSTMENTS			1982	1,290		10			1,290	16
17	IDPA AUDIT ADJUSTMENTS			1983	877		10			877	17
18	IDPA AUDIT ADJUSTMENTS			1984	53,742		VARIOUS			53,742	18
19	IDPA AUDIT ADJUSTMENTS			1985	15,330		15			15,330	19
20	IDPA AUDIT ADJUSTMENTS			1969	28,119		20			28,119	20
21	IDPA AUDIT ADJUSTMENTS			1977	11,869		20			7,246	21
22	IDPA AUDIT ADJUSTMENTS			1986	94,429		VARIOUS			94,429	22
23	IDPA AUDIT ADJUSTMENTS			1989	146,038		VARIOUS			120,418	23
24	DECORATING			1987	3,285		10			3,285	24
25	PARKING LOT			1988	19,937		VARIOUS			19,937	25
26	FIRE ALARM SYSTEM			1990	37,956		VARIOUS			35,613	26
27	NEW ROOF			1992	55,787		10			55,787	27
28	HOT WATER TANK			1992	3,295		10			3,295	28
29	BUILDING PAINTING			1993	7,336		5			7,336	29
30	ROOF REPAIRS			1993	434		10			434	30
31	WATER HEATER			1993	223		15			223	31
32	BOILER REPAIR			1993	1,415		10			1,415	32
33	CODE ALERT FIRE SYSTEM			1995	8,559		10			8,559	33
34	MISC			1997	3,013		10			3,013	34
35	VINYL FLOOR			1998	4,012		5			4,012	35
36	See Next Page										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 ST JOSEPH NURSING HOME # 0005637 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

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	CERAMIC FLOOR FOR NEW TUB	1999	$ 107	$ 5	20	$ 5	$	$ 58	37
38	CARPET ON WALLS	2000	2,668	0	5	0		2,668	38
39	METAMORA TELEPHONE SYSTEM	2000	7,337	734	10	734		7,707	39
40	TOMKAT ROOFING	2001	18,760	1,876	10	1,876		17,822	40
41	HOBERT CORP	2001	1,555	156	10	156		1,482	41
42	ASPHALT REPAIR	2002	2,900	363	8	363		2,900	42
43								0	43
44	75 GALLON 365M ASME WTR HTR	2006	5,225	523	10	523		2,353	44
45	ULTRA CARE 709 BED LAMINATE PANELS	2006	5,809	387	15	387		1,741	45
46	HOYER PROF PATIENT LIFT	2006	3,020	302	10	302		1,359	46
47	HOYER PROF VERTICAL PATIENT LIFT W/ SCALE	2006	4,249	424	10	424		1,908	47
48								0	48
49	CONCRETE SIDEWALK	2007	5,220	348	15	348		1,218	49
50	ROOFING	2007	20,986	2,098	10	2,098		7,343	50
51	FIRE DAMPERS	2007	13,100	874	15	874		3,059	51
52	BEDS (16)	2007	19,904	1,328	15	1,328		4,648	52
53	DOOR ALARM SYSTEM	2007	20,963	1,398	15	1,398		4,893	53
54	FURNITURE & EQUIPMENT - NURSING SERVICE	2008	21,360	1,424	15	1,424		2,355	54
55									55
56	KITCHEN SUPPRESSION HOOD	2010	3,321	554	5	554		554	56
57	MODIFY GAS PIPING TO KITCHEN	2010	1,585	238	5	238		238	57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,565,907	$ 13,225		$ 13,225	$ 0	$ 2,433,843	70

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

Facility Name & ID Number ST JOSEPH NURSING HOME # 0005637 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 158,653	$ 44,216	$ 44,216	$ 0		$ 164,500	71
72	Current Year Purchases				0			72
73	Fully Depreciated Assets	465,884			0			73
74					0			74
75	TOTALS	$ 624,537	$ 44,216	$ 44,216	$ 0		$ 164,500	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	NURSING HOME USE	CHEVY CAPRICE	1987	$ 10,289	$	$	$ 0		$ 10,289	76
77	NURSING HOME USE	PICK-UP	1995	14,590			0		14,590	77
78	NURSING HOME USE	MISC. OTHER	VARIOUS	5,676			0		5,676	78
79	NURSING HOME USE	2001 DODGE RAM 3500 VAN	2002	19,135			0		19,135	79
80	TOTALS			$ 49,690	$ 0	$ 0	$ 0		$ 49,690	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,265,834	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 57,441	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 57,441	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 0	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,648,033	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number ST JOSEPH NURSING HOME # 0005637 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

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	$

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

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

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number ST JOSEPH NURSING HOME # 0005637 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

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?
   - [ ] YES
   - [X] 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 [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$ 0
2	Books and Supplies				0
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	CNA Competency Tests				0
9	TOTALS	$ 0	$ 0	$ 0	$ 0
10	SUM OF line 9, col. 1 and 2 (e)	$ 0			

C. CONTRACTUAL INCOME

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

$ NONE

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number ST JOSEPH NURSING HOME # 0005637 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

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		visits							5
6	Dental Care		visits		THIS WORKSHEET IS NOT APPLICABLE.			#VALUE!		6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$		$	$	#VALUE!	$	14

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

Facility Name & ID Number ST JOSEPH NURSING HOME # 0005637 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 6/30/2010 (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	$ 190,795	$	1
2	Cash-Patient Deposits	4,297		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (272,992))	178,462		3
4	Supply Inventory (priced at COST)	39,916		4
5	Short-Term Investments			5
6	Prepaid Insurance	1,936		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Medicare/Provena Receivable	399,901		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 815,307	$ 0	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	79,003		14
15	Leasehold Improvements, at Historical Cost	1,542,375		15
16	Equipment, at Historical Cost	248,137		16
17	Accumulated Depreciation (book methods)	1,382,235		17
18	Deferred Charges	(2,875,390)		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)**	$ 376,360	$ 0	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,191,667	$ 0	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 541,683	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	7,008		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	156,694		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	FNB - Line of Credit	289,968		36
37	Accrued Expenses	41,342		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,036,695	$ 0	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Due to Motherhouse	4,000		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 4,000	$ 0	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,040,695	$ 0	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 150,972	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,191,667	$ 0	48

***(See instructions.)**

Facility Name & ID Number ST JOSEPH NURSING HOME # 0005637 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 696,866	1
2	Restatements (describe):		2
3	**Net fiscal year 2010 audit adjustments (primarily allowance**	**(91,624)**	3
4	**for doubtful accounts)**		4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 605,242	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(454,270)	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)**	$ (454,270)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 0	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 150,972	24 *

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

Facility Name & ID Number ST JOSEPH NURSING HOME # 0005637 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,276,072	1
2	Discounts and Allowances for all Levels	(1,374,965)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,901,107	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)**	$ 0	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	721	12
13	Barber and Beauty Care	16,516	13
14	Non-Patient Meals	20,234	14
15	Telephone, Television and Radio	0	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients	16,267	18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	24,491	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 78,229	23
	D. Non-Operating Revenue		
24	Contributions	16,196	24
25	Interest and Other Investment Income***	332	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 16,528	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)**	$ 0	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,995,864	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,046,401	31
32	Health Care	2,903,777	32
33	General Administration	1,233,301	33
	B. Capital Expense		
34	Ownership	76,904	34
	C. Ancillary Expense		
35	Special Cost Centers	147,296	35
36	Provider Participation Fee	42,455	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,450,134	40
41	**Income before Income Taxes (line 30 minus line 40)****	(454,270)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (454,270)	43

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

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

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

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

Facility Name & ID Number ST JOSEPH NURSING HOME # 0005637 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

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	1,906	1,917	$ 84,819	$ 44.25	1
2	Assistant Director of Nursing					2
3	Registered Nurses	9,744	9,840	395,094	40.15	3
4	Licensed Practical Nurses	12,824	12,958	608,556	46.96	4
5	CNAs & Orderlies	52,308	52,517	794,164	15.12	5
6	CNA Trainees	1,619	1,619	72,506	44.79	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,584	2,638	95,215	36.10	8
9	Activity Director	1,321	1,337	24,263	18.15	9
10	Activity Assistants	4,444	4,495	56,842	12.64	10
11	Social Service Workers	4,316	4,355	78,674	18.07	11
12	Dietician					12
13	Food Service Supervisor	1,436	1,466	44,863	30.60	13
14	Head Cook	1,223	1,233	22,769	18.47	14
15	Cook Helpers/Assistants	7,615	7,754	135,839	17.52	15
16	Dishwashers	9,118	9,266	96,927	10.46	16
17	Maintenance Workers	2,762	2,841	73,582	25.90	17
18	Housekeepers	7,425	7,584	95,314	12.57	18
19	Laundry	7,802	7,881	117,700	14.93	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,129	7,658	131,785	17.21	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	1,396	1,412	22,588	16.00	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	136,971	138,769	$ 2,951,500 *	$ 21.27	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		$ 7,236	1.3	35
36	Medical Director				36
37	Medical Records Consultant		2,265		37
38	Nurse Consultant				38
39	Pharmacist Consultant		2,537	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				44
45	Social Service Consultant		2,550	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 14,588		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 7,067		50
51	Licensed Practical Nurses		28,270		51
52	Certified Nurse Assistants/Aides		35,338		52
53	TOTAL (lines 50 - 52)		$ 70,675		53

Facility Name & ID Number ST JOSEPH NURSING HOME # 0005637 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
LISA HELMS	Administrator	0	$ 0

TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.) $

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
Provena	Management Fees	$ 260,154
Brown Smith Wallace, L.L.C.	Audit & Accounting	20,515
Kronos Inc.	Payroll Sofware	6,836
Alliance Benefit Group	Employee Benefits Consulting	4,450
Catholic Mutual	Membership	4,000
Walker-Phillips	Audit & Accounting	3,950
Facet	IT Network	3,390
OSF Medical	Medical Services	1,371
CBIZ Valuation	Fixed Asset Accounting	1,009
Employees' Association	Membership	856

TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.) $ 306,530

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 56,435
Unemployment Compensation Insurance	18,392
FICA Taxes	200,057
Employee Health Insurance	273,421
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	0
Less: Sister's Maintenance Adjustment	(5,462)
TOTAL (agree to Schedule V, line 22, col.8)	$ 542,843

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

Description	Line #	Amount
This schedule is not applicable		
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	30,246
Health Care Worker Background Check (Indicate # of checks performed)	
Licenses and Fees	35,447
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 65,693

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ NONE
In-State Travel	70
Seminar Expense	2,958
Vehicle Maintenance and Gas	6,625
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 9,653

**See instructions.

Facility Name & ID Number ST JOSEPH NURSING HOME # 0005637 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

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			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6	THIS WORKSHEET IS NOT APPLICABLE.												
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **CHA, AASHA, LSN, Lacon Chamber of Commerce**

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

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **61,665** Line **10.2**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **42,455**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **NONE** Has any meal income been offset against related costs? **YES** Indicate the amount. $ **20,234**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **NONE**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **In Process**
Firm Name: **BROWN SMITH WALLACE, LLC**

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

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

ST. JOSEPH NURSING HOME
PAGE 5A - NON-ALLOWABLE EXPENSES (RECLASSES AND ADJUSTMENTS) DETAIL
Reporting Period Beginning JULY 1, 2008 and Ending JUNE 30, 2009

Patient, Sister and Employee Meals:

		Detail	Subtotals	Percentages
Meals served to Patients:	Patient Days	30,279		
	Meals per day	3	90,837	90.21%
Meals provided to Sisters (non-patient):	Number of Sisters	9		
	Meals per day	3		
	Days per year	365	9,855	9.79%
	Total Meals Served		**100,692**	**100.00%**

Adjustments for Sisters' Maintenance:

Sisters' portion of dietary and food cost:

Dietary cost	$ 326,362	*From page 3, Line 1, Col. 4*	
Sisters' percentage	9.79%	*From calculation above*	
Sisters' Portion of Dietary Cost	**$ 31,942**	***Adjustment: To Line 1, Schedule V***	
Food cost	$ 231,437	*From page 3, Line 2, Col. 4*	
Sisters' percentage	9.79%	*From calculation above*	
Sisters' Portion of Food Cost	**$ 22,651**	***Adjustment: To Line 2, Schedule V***	

Sisters' portion of building and utilities:

Sisters' portion of building:	Convent (Sisters) Square Footage	2,464	*From prior year - no changes*
	Total Square Footage	66,656	*From prior year - no changes*
	Convent (Sisters) Offset Percentage	3.70%	
Sisters' portion of utilities:	Heat and Other Utilities	$ 134,274	*From page 3, Line 5, Col. 4*
	Sisters' percentage	3.70%	*From calculation above*
	Sisters' Portion of Heat and Other Utilities	**$ 4,964**	***Adjustment: To Line 5, Schedule V***

Employee Benefits in Sisters' Meals:

Dietary Salaries	$ 300,398	*From page 3, Line 1, Col. 1*	
Sisters' percentage	9.79%	*From calculation above*	
Salaries Applicable to Sister's Meals		$ 29,401	
Total Salaries	$ 2,951,500		*From page 4, Line 45, Col. 1*
Employee Benefits	$ 548,305		*From page 3, Line 22, Col. 4*
Employee benefits ratio		18.58%	
Employee Benefits Applicable to Sisters' Meals		$ 5,462	***Adjustment: To Line 22, Schedule V***

Total Adjustments for Sisters' Portion of Costs **$ 65,019**

ST. JOSEPH NURSING HOME
Schedule V - Detail of Line 24 (Total Exceeds $2,000)
Reporting Period Beginning JULY 1, 2009 and Ending JUNE 30, 2010

V--24.3 Travel and Seminar Other

410039-00	Travel	70.00
410219-00	Education	2,708.00
510019-00	Vehicle Maint. & Gas Etc	6,625.00
730119-00	Education	250.00
		9,653.00

ST. JOSEPH NURSING HOME
List of Board of Directors
Reporting Period Beginning JULY 1, 2009 and Ending JUNE 30, 2010

Name	Title
Sister Adriana Zdila	President of the Board
Angela Mehlbrech	Administrator/CEO
Lisa Helms	Administrator as of September 9, 2010
Sister Rudolfia Petrik	Board Member
Sister M. Justina Delonga	Board Member
Sister M. Olga Poluch	Board Member
Sister M. Michael Fox	Secretary/Treasurer

Client: 79733 - Saint Joseph Nursing Home, Inc.
Engagement: 2010 AUD - Saint Joseph Nursing Home, Inc.
Period Ending: 6/30/2010
Trial Balance: 1600 - TB
Workpaper: TB Combined Detail LS - 2

Account	Description	FINAL 6/30/2010
Group : [1.1]	V--1.1 Dietary Salary/Wage	
Subgroup : None		
520017-00	Salaries - Dietary	300,398.00
520018-00	Accrued Vacation - Dietary	0.00
520025-00	Accrued Sick - Dietary	0.00
520117-00	Dietary Supervisor	0.00
520217-00	Dietary Cooks	0.00
520317-00	Dietary Aides	0.00
520417-00	Cooks Assistant	0.00
520517-00	Dietary Pots and Pans	0.00
Subtotal : None		300,398.00
Total [1.1] V--1.1 Dietary Salary/Wage		300,398.00
Group : [1.3]	V--1.3 Dietary Other	
Subgroup : None		
520020-00	Consultant	7,226.00
520029-00	Dishes, Etc	939.00
520039-00	Dietary Chemicals and Supplies	12,351.00
783090-00	Headstart Meals Expense	4,275.00
783092-00	Headstart Labor Expense	1,163.00
Subtotal : None		25,964.00
Total [1.3] V--1.3 Dietary Other		25,964.00
Group : [2.2]	V--2.2 Food Purchase Supplies	
Subgroup : None		
520019-00	Food	231,437.00
Subtotal : None		231,437.00
Total [2.2] V--2.2 Food Purchase Supplies		231,437.00
Group : [3.1]	V--3.1 Housekeeping Salary/Wage	
Subgroup : None		
540017-00	Salaries - Housekeeping	95,314.00
540018-00	Accrued Vacation - Housekeeping	0.00
540025-00	Accrued Sick - Housekeeping	0.00
Subtotal : None		95,314.00
Total [3.1] V--3.1 Housekeeping Salary/Wage		95,314.00
Group : [3.2]	V--3.2 Housekeeping Supplies	
Subgroup : None		
540019-00	Housekeeping Misc Supplies	24,987.00
Subtotal : None		24,987.00
Total [3.2] V--3.2 Housekeeping Supplies		24,987.00
Group : [4.1]	V--4.1 Laundry Salary/Wage	
Subgroup : None		
530017-00	Salaries - Laundry	117,700.00
530018-00	Accrued Vacation - Laundry	0.00
530025-00	Accrued Sick - Laundry	0.00
Subtotal : None		117,700.00
Total [4.1] V--4.1 Laundry Salary/Wage		117,700.00
Group : [4.3]	V--4.3 Laundry Other	
Subgroup : None		
530019-00	Linen & Bedding	1,143.00
530039-00	Laundry Misc Supplies	2,232.00
Subtotal : None		3,375.00
Total [4.3] V--4.3 Laundry Other		3,375.00
Group : [5.3]	V--5.3 Heat and Other Utilities Other	
Subgroup : None		
510029-00	Gas - Cilco	39,521.00
510039-00	Electricity - Integrys	90,204.00
510049-00	Water	4,549.00
Subtotal : None		134,274.00
Total [5.3] V--5.3 Heat and Other Utilities Other		134,274.00
Group : [6.1]	V--6.1 Maintenance Salary/Wage	
Subgroup : None		
510017-00	Salaries - Maintenance	73,582.00
510018-00	Accrued Vacation - Maintenance	0.00
510025-00	Accrued Sick - Maintenance	0.00
Subtotal : None		73,582.00
Total [6.1] V--6.1 Maintenance Salary/Wage		73,582.00
Group : [6.3]	V--6.3 Maintenance Other	
Subgroup : None		
510059-00	Equipment Replacement	7,782.00
510069-00	Environmental Contract Services	21,586.00
510079-00	Misc. Supplies & Exp Maint.	8,049.00
510089-00	Maintenance of Grounds	1,953.00
Subtotal : None		39,370.00
Total [6.3] V--6.3 Maintenance Other		39,370.00
Group : [10.1]	V--10.1 Nursing & Med Records - Salary	
Subgroup : None		
410025-00	Accrued Sick - Administration	0.00
410118-00	Accrued Vacation - Religious	0.00
410125-00	Accrued Sick - Religious	0.00
600015-00	Director of Nursing	0.00
600016-00	Clinical Coordinator	0.00
600017-00	Salaries - Nursing	2,002,105.00
600025-00	Nurses Accrued Sick	0.00
600027-00	Secular Salaries - LPN's	0.00
600028-00	MDS Coordinator	0.00
600029-00	MDS Coordinator Asst.	0.00
600037-00	Secular Salaries - CNA's	0.00
600038-00	Non-Certified Nurses' Aide	0.00
600047-00	Nursing Services Coordinator	0.00
600048-00	Medical Record Consultant	161.00
600078-00	Agency Nursing Staffing	70,676.00
600088-00	Nursing Consultant	0.00
730017-00	Secular Salareis - Rehab	0.00
Subtotal : None		2,072,942.00
Total [10.1] V--10.1 Nursing & Med Records - Salary		2,072,942.00
Group : [10A]	V--10a.1 Therapy	
Subgroup : None		
730021-00	Select Rehab Therapy Expense	0.00
730023-00	RN - Rehab Nurse Wage	0.00
Subtotal : None		0.00
Total [10A] V--10a.1 Therapy		0
Group : [10.2]	V--10.2 Nursing & Med Records Supplies	
Subgroup : None		
600049-00	Supplies & Expense	61,786.00
600050-00	Undergarments/Pads	61,665.00
730019-00	Supplies & Expense "Rehab"	4,763.00
Subtotal : None		128,214.00
Total [10.2] V--10.2 Nursing & Med Records Supplies		128,214.00
Group : [10.3]	V--10.3 Nursing & Med Records - Other	
Subgroup : None		
410229-00	Medical Record Consultant	2,265.00
600018-00	Nursing Accrued Vacation	(64.00)
600020-00	Sisters Services - RN	0.00
600021-00	Sister Services - Ward Clerk	0.00
720017-00	Pharmacist Consultant	2,527.00
730020-00	Consultant-Physical Therapy	0.00
730022-00	Consultant - Occupational Therapy	0.00
740017-00	Secular Speech Therapist	0.00
740020-00	Speech Consultant	0.00
Subtotal : None		4,728.00
Total [10.3] V--10.3 Nursing & Med Records - Other		4,728.00
Group : [11.1]	V--11.1 Activities Salary/Wages	
Subgroup : None		
750017-00	Salaries - Activities	80,779.00
750025-00	Accrued Sick - Activities	0.00
770019-00	Supplies & Expense	326.00
Subtotal : None		81,105.00
Total [11.1] V--11.1 Activities Salary/Wages		81,105.00
Group : [10.4]	V--10.4 Medicare Therapy Other	
Subgroup : None		
790001-00	PT MCA EXPENSE	74,412.00
790002-00	OT MCA EXPENSE	58,192.00
790003-00	ST MCA EXPENSE	18,619.00
800001-00	PT MCB EXPENSE	95,852.00
800002-00	OT MCB EXPENSE	93,725.00
800003-00	ST MCB EXPENSE	18,282.00
810001-00	PT INS EXPENSE	14,737.00
810002-00	OT INS EXPENSE	7,581.00
810003-00	ST INS EXPENSE	2,980.00
820002-00	OT Private Expense	0.00
820003-00	ST Private Expense	0.00
Subtotal : None		384,380.00
Total [10.4] V--10.4 Medicare Therapy Other		384,380.00
Group : [11.2]	V--11.2 Activities Supplies	
Subgroup : None		
750019-00	Supplies & Expense -Activity	5,001.00
Subtotal : None		5,001.00
Total [11.2] V--11.2 Activities Supplies		5,001.00
Group : [11.3]	V--11.3 Activities Other	
Subgroup : None		
730018-00	Sister Services	0.00
750018-00	Accrued Vacation - Activities	0.00
750020-00	Consultant	0.00
750021-00	Entertainment	1,600.00
Subtotal : None		1,600.00
Total [11.3] V--11.3 Activities Other		1,600.00
Group : [12.1]	V--12.1 Social Services Salary/Wage	
Subgroup : None		
760017-00	Salaries - Social Services	78,674.00
760018-00	Social Services Accrued Vacation	0.00
760025-00	Social Service Accrued Sick	0.00
Subtotal : None		78,674.00
Total [12.1] V--12.1 Social Services Salary/Wage		78,674.00
Group : [12.2]	V--12.2 Social Services Supplies	
Subgroup : None		
760019-00	Supplies & Expense - Social Services	0.00
770020-00	Chapel Supplies	218.00
Subtotal : None		218.00
Total [12.2] V--12.2 Social Services Supplies		218.00
Group : [12.3]	V--12.3 Social Services Other	
Subgroup : None		
760020-00	Consultant - Social Services	2,550.00
760029-00	Purchased Services	0.00
770017-00	Chaplains Salary	0.00
Subtotal : None		2,550.00
Total [12.3] V--12.3 Social Services Other		2,550.00
Group : [13.3]	V--13.3 Nurse Aide Training	
Subgroup : None		
600086-00	CNA Class Instruction	803.00
600087-00	CNA Class Supplies	0.00
Subtotal : None		803.00
Total [13.3] V--13.3 Nurse Aide Training		803.00
Group : [17.1]	V--17.1 Administrative	
Subgroup : None		
410016-00	Executive Wages	0.00
Subtotal : None		0.00
Total [17.1] V--17.1 Administrative		0.00
Group : [19.3]	V--19.3 Professional Services Other	
Subgroup : None		
410069-00	Professional Services	46,376.00
410070-00	Provena Management Account	260,154.00
Subtotal : None		306,530.00
Total [19.3] V--19.3 Professional Services Other		306,530.00
Group : [20.3]	V--20.3 Dues, Fees, Subscript & Promos	
Subgroup : None		
410049-00	Advertising & Public Relation	30,246.00
410059-00	Licenses & Dues	35,447.00
Subtotal : None		65,693.00
Total [20.3] V--20.3 Dues, Fees, Subscript & Promos		65,693.00
Group : [21.1]	V--21.1 Clerical & Gen Office Salary	
Subgroup : None		
410017-00	Salaries - Administration	112,300.00
410116-00	Salaries - Religious Fr. Schmitt	19,485.00
Subtotal : None		131,785.00
Total [21.1] V--21.1 Clerical & Gen Office Salary		131,785.00
Group : [21.2]	V--21.2 Clerical & Gen Office Supplies	
Subgroup : None		
410019-00	Office Supplies & Printing	12,164.00
Subtotal : None		12,164.00
Total [21.2] V--21.2 Clerical & Gen Office Supplies		12,164.00
Group : [21.3]	V--21.3 Clerical & Gen Office Other	
Subgroup : None		
410018-00	Sister Services	0.00
410029-00	Telephone & Internet	19,357.00
410030-00	Cable T.V.	6,494.00
410099-00	Miscellaneous & Postage	9,141.00
410100-00	Copier Maintenance	8,250.00
510090-00	Purchased Discounts	0.00
Subtotal : None		43,242.00
Total [21.3] V--21.3 Clerical & Gen Office Other		43,242.00
Group : [22.3]	V--22.3 Employee Ben & PR Taxes Other	
Subgroup : None		
249107-00	Maint. Fee - Employee Loan	0.00
410050-00	Employee Service Awards	725.00
410051-00	Employee Annual Party	1,410.00
410052-00	Employee Physicals	9,519.00
410053-00	Employee Incentives	2,158.00
410054-00	Employee / Resident Vaccine	0.00
410078-00	Unemployment Tax	10,153.00
410079-00	Employee Share FICA-Payroll Tax	208,296.00
410087-00	Employee Health Insurance BCBS	256,072.00
410088-00	Employee Life Insurance	3,537.00
410209-00	Employee Pension Expense	0.00
Subtotal : None		491,870.00
Total [22.3] V--22.3 Employee Ben & PR Taxes Other		491,870.00
Group : [24.3]	V--24.3 Travel and Seminar Other	
Subgroup : None		
410039-00	Travel	70.00
410219-00	Education	2,708.00
510019-00	Vehicle Maint. & Gas, Etc.	6,625.00
510219-00	Education	0.00
520619-00	Education	0.00
600119-00	Education	0.00
730119-00	Education	250.00
750119-00	Education	0.00
760119-00	Education	0.00
Subtotal : None		9,653.00
Total [24.3] V--24.3 Travel and Seminar Other		9,653.00
Group : [26.3]	V--26.3 Insurance - Prop. Liab Malpract	
Subgroup : None		
410089-00	Insurance	172,364.00
Subtotal : None		172,364.00
Total [26.3] V--26.3 Insurance - Prop. Liab Malpract		172,364.00
Group : [30.3]	V--30.3 Depreciation Other	
Subgroup : None		
782019-00	Deprec. - Land Improvements	1,443.00
782029-00	Deprec. - Building & Bldg. Improvem	37,025.00
782039-00	Deprec. - Building Fixtures	2,390.00
782049-00	Deprec. - Furniture & Equipment	11,799.00
782059-00	Deprec. - Vehicles	4,784.00
Subtotal : None		57,441.00
Total [30.3] V--30.3 Depreciation Other		57,441.00
Group : [32.3]	V--32.3 Interest Expense	
Subgroup : None		
783100-00	Interest Expense	19,463.00
Subtotal : None		19,463.00
Total [32.3] V--32.3 Interest Expense		19,463.00
Group : [39.3]	V--39.3 Ancillary Service Center Other	
Subgroup : None		
720019-00	Drugs	20,939.00
720020-00	Vision Care	0.00
720021-00	Pharmacy Medicare A	109,811.00
720022-00	Lab Medicare A	8,949.00
720023-00	X-Ray Medicare A	385.00
720024-00	Oxygen Medicare A	0.00
720029-00	Misc. Medicare A Expense	0.00
Subtotal : None		140,084.00
Total [39.3] V--39.3 Ancillary Service Center Other		140,084.00
Group : [40.2]	V--40.2 Barber and Beauty Shops Supplies	
Subgroup : None		
780029-00	Supplies for Beauty and Barber	0.00
Subtotal : None		0.00
Total [40.2] V--40.2 Barber and Beauty Shops Supplies		0.00
Group : [40.3]	V--40.3 Barber and Beauty Shops Other	
Subgroup : None		
780019-00	Professional Services Beauty Shop	7,212.00
Subtotal : None		7,212.00
Total [40.3] V--40.3 Barber and Beauty Shops Other		7,212.00
Group : [42.3]	V--42.3 Provider Participation Fee Other	

Subgroup : None		
410230-00	Illinois Dept. of Public Aid Fee	42,455.00
Subtotal : None		**42,455.00**
Total [42.3] V--42.3 Provider Participation Fee Other		**42,455.00**
Group : [1A]	Pg 19 - Sch XVII - 1	
Subgroup : None		
205001-00	Room	(4,718,918.00)
205002-00	Resident Refunds	0.00
205005-00	R&B Skilled MCA	0.00
205006-00	R&B Skilled MGC	(488,984.00)
205007-00	R&B Skilled MCB	(37,921.00)
205008-00	Contractual Adj - R&B MCA	(569,906.00)
205009-00	Contractual Adj - R&B MGC	0.00
205011-00	Ancillary Supplies - MCA	(12,564.00)
205012-00	Ancillary Supplies - MGC	(9,779.00)
205014-00	Ancillary Supplies - PVT	(19.00)
205015-00	Pharmacy - MCA	(100,937.00)
205016-00	Pharmacy - MGC	(8,302.00)
205018-00	X-Ray MCA	(1,759.00)
205021-00	Contractual Adj - Ancillaries MCA	387,879.00
205022-00	Contractual Adj - Ancillaries MGC/INS	(9,216.00)
205023-00	Contractual Adj - Ancillaries MCB	20,670.00
208001-00	PT MCA REVENUE	(125,613.00)
208002-00	OT MCA REVENUE	(109,779.00)
208003-00	ST MCA REVENUE	(37,598.00)
209001-00	PT MCB REVENUE	(134,751.00)
209002-00	OT MCB REVENUE	(132,472.00)
209003-00	ST MCB REVENUE	(24,149.00)
210001-00	PT INS REVENUE	(27,063.00)
210002-00	OT INS REVENUE	(12,338.00)
210003-00	ST INS REVENUE	(8,718.00)
211002-01	Physical Therapy - Public Aid	0.00
211002-02	Misc. Therapy - Private	(6.00)
211032-00	Physical Therapy, IPMR	0.00
221002-01	Pharmacy - Public Aid	(8,399.00)
221002-02	Pharmacy - Private	0.00
231002-01	Special Diets - Public Aid	(6,556.00)
231002-02	Special Diets - Private	(3,794.00)
235012-01	Injection Supplies - Public Aid	(23,026.00)
235012-02	Injection Supplies - Private	(7,294.00)
236002-00	Nursing Supplies	237.00
236002-01	Spec. Nursing Supplies - PA	(11,517.00)
236002-02	Spec. Nursing Supplies - PV	(6,995.00)
236012-01	Undergarments - Public Aid	(35,236.00)
236012-02	Undergarments - Private	(11,145.00)
236022-00	Wheelchair Rental	(100.00)
Subtotal : None		**(6,276,068.00)**
Total [1A] Pg 19 - Sch XVII - 1		**(6,276,068.00)**
Group : [2A]	Pg 19 - Sch XVII - 2	
Subgroup : None		
250014-00	State - Write Offs	1,370,799.00
250026-00	Other Allowances / Hill Burton	4,166.00
250084-00	Internet	0.00
Subtotal : None		**1,374,965.00**
Total [2A] Pg 19 - Sch XVII - 2		**1,374,965.00**
Group : [12A]	Pg 19, Sch XVII - 12	
Subgroup : None		
349106-00	Vending Machine	(721.00)
805100-00	Vending Machines	0.00
Subtotal : None		**(721.00)**
Total [12A] Pg 19, Sch XVII - 12		**(721.00)**
Group : [13A]	Pg 19 - Sch XVII - 13	
Subgroup : None		
348003-00	Beauty/Barber	0.00
348003-01	Hairdresser - Public Aid	(95.00)
348003-02	Hairdresser - Private	(16,421.00)
Subtotal : None		**(16,516.00)**
Total [13A] Pg 19 - Sch XVII - 13		**(16,516.00)**
Group : [14A]	Pg 19 - Sch XVII - 14	
Subgroup : None		
349101-00	Headstart Meals Income	(9,088.00)
349102-00	Cafeteria, Scrubs, Misc	(11,146.00)
781021-00	Headstart Meals Income	0.00
781029-00	Cafeteria	0.00
Subtotal : None		**(20,234.00)**
Total [14A] Pg 19 - Sch XVII - 14		**(20,234.00)**
Group : [40.4]	V--40.1 Bad Debt Expense	
Subgroup : None		
410075-00	Bad Debt Expense	143,552.00
Subtotal : None		**143,552.00**
Total [40.4] V--40.1 Bad Debt Expense		**143,552.00**
Group : [15A]	Pg 19 - Sch XVII - 15	
Subgroup : None		
347022-02	Cable T.V. - Private	0.00
Subtotal : None		**0.00**
Total [15A] Pg 19 - Sch XVII - 15		**0.00**
Group : [21A]	Pg 19 - Sch XVII - 21	
Subgroup : None		
347002-01	Miscellaneous - Public Aid	(10,435.00)
347002-02	Miscellaneous - Private	(7,216.00)
349104-00	Miscellaneous	0.00
350021-00	Employee Purchases	0.00
350070-00	Employee Purchases	(6,840.00)
803100-00	Miscellaneous	0.00
Subtotal : None		**(24,491.00)**
Total [21A] Pg 19 - Sch XVII - 21		**(24,491.00)**
Group : [24A]	Pg 19 - Sch XVII - 24	
Subgroup : None		
349000-00	Contribution revenue	0.00
349112-00	Memorial & Gifts	(16,196.00)
813000-00	Memorials & Gifts	0.00
Subtotal : None		**(16,196.00)**
Total [24A] Pg 19 - Sch XVII - 24		**(16,196.00)**
Group : [25A]	Pg 19 - Sch XVII - 25	
Subgroup : None		
349103-00	Interest Earned	(332.00)
801100-00	Interest Earned	0.00
Subtotal : None		**(332.00)**
Total [25A] Pg 19 - Sch XVII - 25		**(332.00)**
Group : [28AA]	Pg 19 - Sch XVII - 28	
Subgroup : None		
349100-00	Sisters Maintenance	(16,267.00)
781019-00	Sisters Maintenance	0.00
Subtotal : None		**(16,267.00)**
Total [28AA] Pg 19 - Sch XVII - 28		**(16,267.00)**
Group : [BS]	Balance Sheet Accounts	
Subgroup : [A]	**Assets**	
101200-00	1st Nat'l Bank Lacon - General	101,273.00
101230-00	1st Nat'l Bank - Payroll	30,590.00
101240-00	Resident Trust Fund	0.00
101250-00	F.N.B. Lacon 90 Day CD	0.00
101255-00	Merill Lunch Money Market	0.00
101256-00	Interest receivable	0.00
101260-00	Petty Cash	375.00
101261-00	Employee Casual Day Fund	1,823.00
101270-00	Depreciation Fund	3,416.00
101271-00	Fundraising Fund	8,851.00
101272-00	Memorial Fund	23,980.00
101273-00	Activity Fund	20,487.00
	TOTAL CASH	190,795.00
101276-00	Resident Trust Fund	4,297.00
105100-00	Patient Accounts Rec.	451,454.00
105101-00	Allowance	(272,992.00)
121300-00	Supplies	39,916.00
131100-00	Unexpired Insurance	1,936.00
131300-00	Due From Medicare	31,274.00
105500-00	Accrued Interest Receivable	(58.00)
105600-00	A/R Provena Medicare Billing	368,685.00
		399,901.00
105200-00	Patient Accounts Refunds	0.00
105250-00	Promises to give	0.00
105300-00	Misc. A/R & Sister's Maint.	0.00
131200-00	Other Prepaid Expenses	0.00
141100-00	Land Improvements	79,003.00
141200-00	Buildings	1,542,375.00
141250-00	Building Improvements	248,137.00
141300-00	Building Fixtures & Equipment	605,574.00
141400-00	Furniture & Equipment	660,622.00
141500-00	Vehicles	100,356.00
143100-00	Minor Equipment	15,683.00
		1,382,235.00
142100-00	Accum.Deprc-Land Improvement	(82,855.00)
142200-00	Accum.Deprc - Bldg & Bldg .Improvem	(1,528,372.00)
142300-00	Accum.Deprc - Bldg.Fixtures & Eq	(569,354.00)
142400-00	Accum.Deprc-Furniture & Equip.	(616,227.00)
142500-00	Accum.Depreciation - Vehicles	(78,582.00)
		(2,875,390.00)
Subtotal [A] Assets		**1,191,667.00**
Subgroup : [B]	**Liab & Net Assets**	
221300-00	Accounts Payable - Trade	(537,386.00)
221500-00	Resident Trust Fund	(4,297.00)
		(541,683.00)
222100-00	Federal Income Tax Withheld	(8,935.00)
222200-00	FICA Taxes Payable	(18,270.00)
222250-00	Unemployment Taxes	0.00
222300-00	State Income Tax Withheld	(3,088.00)
222350-00	Wage Garnishment Payable	0.00
222400-00	Employee Insurance Withheld	0.00
222450-00	Employee Pension Loan Payments	(75.00)
222460-00	Employee Pension American Funds	(290.00)
222510-00	Disability Insurance Withheld	0.00
224000-00	Accrued Payroll	(31,414.00)
226190-00	Accrued Sick	(24,389.00)
231100-00	Accrued Vacation	(70,233.00)
		(156,694.00)
222000-00	First National Bank - L.O.C.	(289,958.00)
221400-00	A/P Provena Medicare Billing	(7,008.00)
221350-00	Accrued Expenses	7,262.00
221360-00	Accrued Exp/Life Ser Nsek Trust	(48,624.00)
		(41,362.00)
231200-00	DSF Installment Loan	(4,000.00)
236100-00	Deferred Revenue - Prepayments	0.00
260250-00	Undesignated Retained Earnings	(803,242.00)
Subtotal [B] Liab & Net Assets		**(1,645,937.00)**
Subgroup : None		
Subtotal : None		**0.00**
Total [BS] Balance Sheet Accounts		**(454,270.00)**
	Sum of Account Groups	**4.00**
	Net (Income) Loss	**454,274.00**