		FOR BHF USE					

LL1

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.

2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

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 7/1/2010 to 6/30/2011 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: 7/1/2010 Ending: 6/30/2011

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)	8	2,920	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)	85	31,025	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	0	0	2,585	2,585	8
9	SNF/PED					9
10	ICF	18,228	9,896	0	28,124	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,228	9,896	2,585	30,709	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.47%

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 2,585

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: 7/1/10 - 6/31/11 Fiscal Year: 7/1/10 - 6/31/11

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

Facility Name & ID Number ST JOSEPH NURSING HOME # 0005637 Report Period Beginning: 7/1/2010 Ending: 6/30/2011

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	330,032		35,071	365,103		365,103	(35,282)	329,821			1
2	Food Purchase		237,098		237,098		237,098	(69,349)	167,749			2
3	Housekeeping	104,117	27,404		131,521		131,521		131,521			3
4	Laundry	134,546		3,744	138,290		138,290		138,290			4
5	Heat and Other Utilities			139,436	139,436		139,436	(5,154)	134,282			5
6	Maintenance	79,402		34,927	114,329		114,329		114,329			6
7	Other (specify):*											7
8	TOTAL General Services	648,097	264,502	213,178	1,125,777		1,125,777	(109,785)	1,015,992			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,976,152	119,100	69,822	2,165,074		2,165,074		2,165,074			10
10a	Therapy			379,928	379,928		379,928		379,928			10a
11	Activities	70,863	3,042	2,065	75,970		75,970		75,970			11
12	Social Services	94,862	214	2,000	97,076		97,076		97,076			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,141,877	122,356	453,815	2,718,048		2,718,048		2,718,048			16
	C. General Administration											
17	Administrative	86,051			86,051		86,051		86,051			17
18	Directors Fees											18
19	Professional Services			152,561	152,561		152,561		152,561			19
20	Dues, Fees, Subscriptions & Promotions			54,028	54,028		54,028		54,028			20
21	Clerical & General Office Expenses	191,350	9,513	45,986	246,849		246,849	(7,549)	239,300			21
22	Employee Benefits & Payroll Taxes			561,782	561,782		561,782	(5,841)	555,941			22
23	Inservice Training & Education											23
24	Travel and Seminar			15,437	15,437		15,437		15,437			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			52,916	52,916		52,916		52,916			26
27	Other (specify):* Bad Debt Expense			44,897	44,897		44,897		44,897			27
28	TOTAL General Administration	277,401	9,513	927,607	1,214,521		1,214,521	(13,390)	1,201,131			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,067,375	396,371	1,594,600	5,058,346		5,058,346	(123,175)	4,935,171			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: 7/1/2010 Ending: 6/30/2011

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		57,441			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			18,126	18,126		18,126	(18,126)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			75,567	75,567		75,567	(18,126)	57,441			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			142,649	142,649		142,649		142,649			39
40	Barber and Beauty Shops			9,831	9,831		9,831		9,831			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			50,918	50,918		50,918		50,918			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			203,398	203,398		203,398		203,398			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,067,375	396,371	1,873,565	5,337,311		5,337,311	(141,301)	5,196,010			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: 7/1/2010 Ending: 6/30/2011

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	(19,104)	2		4
5	Telephone, TV & Radio in Resident Rooms	(7,549)	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	(18,126)	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	(27,333)	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		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)**	$ (72,112)		$	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)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (72,112)		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: 7/1/2010

Ending: 6/30/2011

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Sister's Portion of Dietary Costs	$ (35,282)	1	1
2	Sister's Portion of Food Costs	(22,912)	2	2
3	Sister's Portion of Heat and Other Utilities	(5,154)	5	3
4	Sister's Portion of Employee Benefits in Meals	(5,841)	22	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(69,189)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number ST JOSEPH NURSING HOME # 0005637 Report Period Beginning: 7/1/2010 Ending: 6/30/2011

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	(35,282)	0	0	0	0	0	0	0	0	0	0	(35,282)	1
2	Food Purchase	(69,349)	0	0	0	0	0	0	0	0	0	0	(69,349)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(5,154)	0	0	0	0	0	0	0	0	0	0	(5,154)	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	(109,785)	0	0	0	0	0	0	0	0	0	0	(109,785)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(7,549)	0	0	0	0	0	0	0	0	0	0	(7,549)	21
22	Employee Benefits & Payroll Taxes	(5,841)	0	0	0	0	0	0	0	0	0	0	(5,841)	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	(13,390)	0	0	0	0	0	0	0	0	0	0	(13,390)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(123,175)	0	0	0	0	0	0	0	0	0	0	(123,175)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number ST JOSEPH NURSING HOME # 0005637 **Report Period Beginning:** 7/1/2010 **Ending:** 6/30/2011

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(18,126)	0	0	0	0	0	0	0	0	0	0	(18,126)	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**	(18,126)	0	0	0	0	0	0	0	0	0	0	(18,126)	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)**	(141,301)	0	0	0	0	0	0	0	0	0	0	(141,301)	45

Facility Name & ID Number ST JOSEPH NURSING HOME # 0005637 Report Period Beginning: 7/1/2010 Ending: 6/30/2011

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as 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: 7/1/2010 Ending: 6/30/2011

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		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: 7/1/2010 Ending: 6/30/2011

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	Bank of Lacon		X	Working Capital	$1,675.00	8/11/05	$ 350,000	$ 277,968	11/15/11	6.5000	$ 18,126	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$1,675.00		$ 350,000	$ 277,968			$ 18,126	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 350,000	$ 277,968			$ 18,126	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: 7/1/2010 Ending: 6/30/2011

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: 7/1/2010 Ending: 6/30/2011

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 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).		$	3
4. Real Estate Tax accrual used for 2011 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:			
	2006		8
	2007		9
	2008		10
	2009		11
	2010		12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2010	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

THIS WORKSHEET IS NOT APPLICABLE.

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.

2010 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 2010 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 2010.

	(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	$	$

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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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: 7/1/2010 Ending: 6/30/2011

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: 7/1/2010 Ending: 6/30/2011

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	$ 465,065	$ 9,301	50	$ 9,301	$	$ 427,860	4
5	50			1969	776,093	15,524	50	15,524		651,918	5
6				2010	5,818	388	15	388		388	6
7				1968	530,041					530,041	7
8											8
	Improvement Type**										
9	Fully Depreciated Improvements (1968- 2000)			1968	514,662		5 - 20			514,662	9
10											10
11	MISC			1968	6,160	123	50	123		5,298	11
12	GARAGE			1972	2,491	50	50	50		1,943	12
13	FINISH BASEMENT			1973	6,343	127	50	127		4,821	13
14	WINDOW			1974	900	18	50	18		666	14
15	INSULATION			1976	21,986	440	50	440		15,390	15
16	ROOF			1980	16,049	321	50	321		9,950	16
17	CERAMIC FLOOR FOR NEW TUB			1999	107	5	20	5		69	17
18	TOMKAT ROOFING			2001	18,760	1,876	10	1,876		18,760	18
19	HOBERT CORP			2001	1,555	156	10	156		1,555	19
20	75 GALLON 365M ASME WTR HTR			2006	5,225	523	10	523		2,612	20
21	ULTRA CARE 709 BED LAMINATE PANELS			2006	5,809	387	15	387		1,936	21
22	HOYER PROF PATIENT LIFT			2006	3,020	302	10	302		1,510	22
23	HOYER PROF VERTICAL PATIENT LIFT W/ SCALE			2006	4,249	425	10	425		2,124	23
24	CONCRETE SIDEWALK			2007	5,220	348	15	348		1,044	24
25	ROOFING			2007	20,986	2,099	10	2,099		6,296	25
26	FIRE DAMPERS			2007	13,100	873	15	873		3,493	26
27	BEDS (16)			2007	19,904	1,327	15	1,327		3,980	27
28	DOOR ALARM SYSTEM			2007	20,963	1,398	15	1,398		4,192	28
29											29
30	FURNITURE & EQUIPMENT - NURSING SERVICE			2008	21,360	1,424	15	1,424		2,864	30
31	KITCHEN SUPPRESSION HOOD			2010	3,321	664	5	664		664	31
32	MODIFY GAS PIPING TO KITCHEN			2010	1,585	317	5	317		317	32
33	AIR CONDITIONING UNIT			2011	45,717	2,286	20	2,286		2,286	33
34	MEDICAL EQUIPMENT - DEFIBRILATOR			2011	1,562	157	10	157		157	34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number ST JOSEPH NURSING HOME # 0005637 Report Period Beginning: 7/1/2010 Ending: 6/30/2011

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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			$	$		$	$	$	37
38									38
39	THIS WORKSHEET IS NOT APPLICABLE								39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,538,051	$ 40,858		$ 40,858	$	$ 2,216,796	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: 7/1/2010 Ending: 6/30/2011

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	$ 9,654	$ 9,654	$		$ 125,536	71
72	Current Year Purchases	21,449	2,145	2,145			2,145	72
73	Fully Depreciated Assets	501,969					501,969	73
74								74
75	TOTALS	$ 682,071	$ 11,799	$ 11,799	$		$ 629,650	75

D. Vehicle Costs. (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	Fully Depreciated (1987-2002)	1987	$ 53,490	$	$	$		$ 53,490	76
77	NURSING HOME USE	2008 MED DUTY VEHICLE	2008	46,866	4,784	4,784			34,466	77
78										78
79										79
80	TOTALS			$ 100,356	$ 4,784	$ 4,784	$		$ 87,956	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)	$ 3,346,178	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 57,441	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 57,441	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,934,402	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: 7/1/2010 Ending: 6/30/2011

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.	/2012	$
13.	/2013	$
14.	/2014	$

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: 7/1/2010 Ending: 6/30/2011

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

C. CONTRACTUAL INCOME

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

$ NONE

D. NUMBER OF CNAs TRAINED

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

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

Facility Name & ID Number ST JOSEPH NURSING HOME # 0005637 Report Period Beginning: 7/1/2010 Ending: 6/30/2011

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: 7/1/2010 Ending: 6/30/2011

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 6/30/2011 (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	$ 429,495	$	1
2	Cash-Patient Deposits	5,596		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (271,338))	(134,418)		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	592,025		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 934,550	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	79,003		13
14	Buildings, at Historical Cost	1,542,375		14
15	Leasehold Improvements, at Historical Cost	916,673		15
16	Equipment, at Historical Cost	782,427		16
17	Accumulated Depreciation (book methods)	(2,934,402)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 386,076	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,320,626	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 826,965	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	12,530		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	147,947		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	277,968		36
37	Accrued Expenses	20,886		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,286,296	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,286,296	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 34,330	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,320,626	$	48

***(See instructions.)**

Facility Name & ID Number ST JOSEPH NURSING HOME # 0005637 Report Period Beginning: 7/1/2010 Ending: 6/30/2011

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 118,126	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 118,126	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(83,796)	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)**	$ (83,796)	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)**	$ 34,330	24 *

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

Facility Name & ID Number ST JOSEPH NURSING HOME # 0005637 Report Period Beginning: 7/1/2010 Ending: 6/30/2011

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	$ 6,394,081	1
2	Discounts and Allowances for all Levels	(1,340,330)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,053,751	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	796	12
13	Barber and Beauty Care	17,886	13
14	Non-Patient Meals	19,104	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	16,050	18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	27,333	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 81,169	23
	D. Non-Operating Revenue		
24	Contributions	118,340	24
25	Interest and Other Investment Income***	255	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 118,595	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)**	$ 5,253,515	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,125,777	31
32	Health Care	2,718,048	32
33	General Administration	1,214,521	33
	B. Capital Expense		
34	Ownership	75,567	34
	C. Ancillary Expense		
35	Special Cost Centers	152,480	35
36	Provider Participation Fee	50,918	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,337,311	40
41	**Income before Income Taxes (line 30 minus line 40)****	(83,796)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (83,796)	43

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? N/A 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: 7/1/2010 Ending: 6/30/2011

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	2,080	2,096	$ 60,832	$ 29.02	1
2	Assistant Director of Nursing					2
3	Registered Nurses	11,805	12,074	316,780	26.24	3
4	Licensed Practical Nurses	25,539	25,804	538,152	20.86	4
5	CNAs & Orderlies	67,294	68,812	851,874	12.38	5
6	CNA Trainees	8,769	8,939	96,325	10.78	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,118	2,190	58,854	26.87	8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	2,038	2,038	44,734	21.95	13
14	Head Cook	6,130	6,358	62,858	9.89	14
15	Cook Helpers/Assistants	20,776	21,576	189,722	8.79	15
16	Dishwashers	3,656	3,950	32,717	8.28	16
17	Maintenance Workers	4,741	4,897	79,402	16.21	17
18	Housekeepers	11,141	11,821	104,117	8.81	18
19	Laundry	12,475	12,943	134,546	10.40	19
20	Administrator	2,080	2,160	86,051	39.84	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,080	2,180	36,067	16.54	23
24	Clerical	11,083	11,830	136,865	11.57	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	12,767	12,992	164,990	12.70	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,641	3,681	53,334	14.49	31
32	Other Health Care(specify)					32
33	Other(specify) Religious	2,080	2,080	19,155	9.21	33
34	TOTAL (lines 1 - 33)	212,293	218,421	$ 3,067,375 *	$ 14.04	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	260	$ 7,786	1.3	35
36	Medical Director				36
37	Medical Records Consultant	8	522	10.3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	96	5,344	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	33	2,000	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	397	$ 15,652		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	361	$ 14,428	10.1	50
51	Licensed Practical Nurses	757	27,249	10.1	51
52	Certified Nurse Assistants/Aides	1,114	22,279	10.1	52
53	TOTAL (lines 50 - 52)	2,232	$ 63,956		53

Facility Name & ID Number ST JOSEPH NURSING HOME # 0005637 Report Period Beginning: 7/1/2010 Ending: 6/30/2011

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
LISA HELMS	Administrator	0	$ 86,051
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 86,051

B. Administrative - Other

Description	Amount
This schedule is not applicable	$
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	$ 87,825
Brown Smith Wallace, LLC	Audit & Accounting	30,980
Facet	IT Network	14,431
Kronos Inc.	Payroll Sofware	7,374
Alliance Benefit Group	Employee Benefits Consulting	6,120
Walker-Phillips	Medicare Cost Report	4,109
CBIZ Valuation	Fixed Asset Accounting	1,008
OSF Medical	Medical Services	325
National Elevator	Fixed Asset	300
Accu-Med Services	Medical Services	50
Medifax-EDI, LLC	Medical Services	39
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 152,561

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 101,470
Unemployment Compensation Insurance	21,300
FICA Taxes	205,314
Employee Health Insurance	223,548
Employee Meals	1,887
Illinois Municipal Retirement Fund (IMRF)*	
Employee Incentives	8,263
Less: Sister's Maintenance Adjustment	(5,841)
TOTAL (agree to Schedule V, line 22, col.8)	$ 555,941

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	27,915
Health Care Worker Background Check	400
(Indicate # of checks performed 40)	
Patient Background Checks	
Licenses and Fees	25,713
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 54,028

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ NONE
In-State Travel	1,314
Seminar Expense	5,936
Vehicle Maintenance and Gas	8,187
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 15,437

**See instructions.

Facility Name & ID Number ST JOSEPH NURSING HOME # 0005637 Report Period Beginning: 7/1/2010 Ending: 6/30/2011

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

Facility Name & ID Number ST JOSEPH NURSING HOME # 0005637 Report Period Beginning: 7/1/2010 Ending: 6/30/2011

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 politica 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? **20**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **53,562** Line **10.2**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **50,918**
This amount is to be recorded on line 42 of Schedule V.

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

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

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **Yes - see pg 24** 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. $ **19,104**

(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, L.L.C.**

(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, 2010 and Ending JUNE 30, 2011

Patient, Sister and Employee Meals:

		Detail	Subtotals	Percentages
Meals served to Patients:	Patient Days	30,709		
	Meals per day	3	92,127	90.34%
Meals provided to	Number of Sisters	9		
Sisters (non-patient):	Meals per day	3		
	Days per year	365	9,855	9.66%
	Total Meals Served		**101,982**	**100.00%**

Adjustments for Sisters' Maintenance:

Sisters' portion of dietary and food cost:

Dietary cost	$ 365,103	*From page 3, Line 1, Col. 4*	
Sisters' percentage	9.66%	*From calculation above*	
Sisters' Portion of Dietary Cost	**$ 35,282**	***Adjustment: To Line 1, Schedule V***	
Food cost	$ 237,098	*From page 3, Line 2, Col. 4*	
Sisters' percentage	9.66%	*From calculation above*	
Sisters' Portion of Food Cost	**$ 22,912**	***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	$ 139,436	*From page 3, Line 5, Col. 4*	
Sisters' percentage	3.70%	*From calculation above*	
Sisters' Portion of Heat and Other Utilities	**$ 5,154**	***Adjustment: To Line 5, Schedule V***	

Sisters' portion of building depreciation expense: Building Depreciation Exp	**$ -**	*From G/L Account No. 782029-00*	
Sisters' percentage	3.70%	*From calculation above*	
Sister's Portion of Building Depreciation	**$ -**	***Adjustment: To Line 36, Schedule V (also see p 13 of CR)***	

Employee Benefits in Sisters' Meals:

Dietary Salaries	$ 330,032	*From page 3, Line 1, Col. 1*	
Sisters' percentage	9.66%	*From calculation above*	
Salaries Applicable to Sister's Meals		$ 31,893	
Total Salaries	$ 3,067,375	*From page 4, Line 45, Col. 1*	
Employee Benefits	$ 561,782	*From page 3, Line 22, Col. 4*	
Employee benefits ratio	18.31%		
Employee Benefits Applicable to Sisters' Meals		$ 5,841	***Adjustment: To Line 22, Schedule V***

Total Adjustments for Sisters' Portion of Costs **$ 69,189**

ST. JOSEPH NURSING HOME

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

Reporting Period Beginning JULY 1, 2010 and Ending JUNE 30, 2011

V--24.3 Travel and Seminar Other

410039-00	Travel	1,314.00
410219-00	Education	819.00
510019-00	Vehicle Maint. & Gas, Etc.	8,187.00
520619-00	Education	80.00
600119-00	Education	5,037.00
		15,437.00

ST. JOSEPH NURSING HOME

List of Board of Directors

Reporting Period Beginning JULY 1, 2010 and Ending JUNE 30, 2011

Name	Title
Sister Loretta Matas	President of the Board
Lisa Helms	Administrator
Sister Rudolfia Petrik	Board Member
Sister M. Justina Delonga	Board Member
Sister M. Olga Poluch	Board Member
Sister M. Michael Fox	Secretary/Treasurer