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.

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

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 7/1/2011 to 6/30/2012 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: 7/1/2011 Ending: 6/30/2012

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	5	Skilled (SNF)	5	1,825	1
2		Skilled Pediatric (SNF/PED)			2
3	88	Intermediate (ICF)	88	32,208	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	93	TOTALS	93	34,033	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	1,034	427	2,172	3,633	8
9	SNF/PED					9
10	ICF	16,028	9,455	0	25,483	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,062	9,882	2,172	29,116	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.55%

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)
Headstart Program and Meals provided for Sheriff's Department

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 [ ] NO [ ] If YES, enter number of beds certified 93 and days of care provided

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: 7/1/11-6/30/12 Fiscal Year: 7/1/11-6/30/12

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

Facility Name & ID Number ST JOSEPH NURSING HOME # 0005637 **Report Period Beginning:** 7/1/2011 **Ending:** 6/30/2012

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	322,569		39,076	361,645		361,645	(3,962)	357,683			1
2	Food Purchase		211,285		211,285		211,285	(60,792)	150,493			2
3	Housekeeping	90,328	25,558		115,886		115,886		115,886			3
4	Laundry	102,505		2,771	105,276		105,276		105,276			4
5	Heat and Other Utilities			114,222	114,222		114,222	(4,222)	110,000			5
6	Maintenance	77,834		32,539	110,373		110,373		110,373			6
7	Other (specify):*											7
8	**TOTAL General Services**	593,236	236,843	188,608	1,018,687		1,018,687	(68,976)	949,711			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,853,748	119,591	7,596	1,980,935		1,980,935		1,980,935			10
10a	Therapy			176,950	176,950		176,950		176,950			10a
11	Activities	51,620	1,862	1,740	55,222		55,222		55,222			11
12	Social Services	91,950	199	1,160	93,309		93,309		93,309			12
13	CNA Training											13
14	Program Transportation			5,547	5,547		5,547		5,547			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,997,318	121,652	192,993	2,311,963		2,311,963		2,311,963			16
	C. General Administration											
17	Administrative	16,668			16,668		16,668		16,668			17
18	Directors Fees											18
19	Professional Services			66,047	66,047		66,047		66,047			19
20	Dues, Fees, Subscriptions & Promotions			31,003	31,003		31,003		31,003			20
21	Clerical & General Office Expenses	273,535	7,013	31,803	312,351		312,351	(7,830)	304,521			21
22	Employee Benefits & Payroll Taxes			559,016	559,016		559,016	(6,346)	552,670			22
23	Inservice Training & Education											23
24	Travel and Seminar			10,449	10,449		10,449		10,449			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			43,667	43,667		43,667		43,667			26
27	Other (specify):*											27
28	**TOTAL General Administration**	290,203	7,013	741,985	1,039,201		1,039,201	(14,176)	1,025,025			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,880,757	365,508	1,123,586	4,369,851		4,369,851	(83,153)	4,286,698			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: 7/1/2011 Ending: 6/30/2012

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			16,017	16,017		16,017	(16,017)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			73,458	73,458		73,458	(16,017)	57,441			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			134,953	134,953		134,953		134,953			39
40	Barber and Beauty Shops			19,586	19,586		19,586		19,586			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			261,816	261,816		261,816		261,816			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			416,355	416,355		416,355		416,355			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,880,757	365,508	1,613,399	4,859,664		4,859,664	(99,170)	4,760,494			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: 7/1/2011 Ending: 6/30/2012

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	(20,759)	2		4
5	Telephone, TV & Radio in Resident Rooms	(7,830)	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	(16,017)	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	(18,612)	2		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				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)**	$ (63,218)		$	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))**	$ (63,218)		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: 7/1/2011

Ending: 6/30/2012

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Sister's Portion of Dietary Costs	$ (3,962)	1	1
2	Sister's Portion of Food Costs	(21,421)	2	2
3	Sister's Portion of Heat and Other Utilities	(4,222)	5	3
4	Sister's Portion of Employee Benefits in Meals	(6,346)	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**	(35,952)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number ST JOSEPH NURSING HOME # 0005637 **Report Period Beginning:** 7/1/2011 **Ending:** 6/30/2012

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	(3,962)	0	0	0	0	0	0	0	0	0	0	(3,962)	1
2	Food Purchase	(60,792)	0	0	0	0	0	0	0	0	0	0	(60,792)	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	(4,222)	0	0	0	0	0	0	0	0	0	0	(4,222)	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**	(68,976)	0	0	0	0	0	0	0	0	0	0	(68,976)	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	(7,830)	0	0	0	0	0	0	0	0	0	0	(7,830)	21
22	Employee Benefits & Payroll Taxes	(6,346)	0	0	0	0	0	0	0	0	0	0	(6,346)	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**	(14,176)	0	0	0	0	0	0	0	0	0	0	(14,176)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(83,153)	0	0	0	0	0	0	0	0	0	0	(83,153)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number ST JOSEPH NURSING HOME # 0005637 **Report Period Beginning:** 7/1/2011 **Ending:** 6/30/2012

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	(16,017)	0	0	0	0	0	0	0	0	0	0	(16,017)	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**	(16,017)	0	0	0	0	0	0	0	0	0	0	(16,017)	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)**	(99,170)	0	0	0	0	0	0	0	0	0	0	(99,170)	45

Facility Name & ID Number ST JOSEPH NURSING HOME # 0005637 Report Period Beginning: 7/1/2011 Ending: 6/30/2012

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: 7/1/2011 Ending: 6/30/2012

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
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								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number ST JOSEPH NURSING HOME # 0005637 Report Period Beginning: 7/1/2011 Ending: 6/30/2012

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: 7/1/2011 Ending: 6/30/2012

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: 7/1/2011 Ending: 6/30/2012

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	$ 400,000	$ 266,154	11/20/12	6.0000	$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$1,675.00		$ 400,000	$ 266,154			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 400,000	$ 266,154			$	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: 7/1/2011 Ending: 6/30/2012

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 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 2012 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:			
	2007		8
	2008		9
	2009		10
	2010		11
	2011		12

THIS WORKSHEET IS NOT APPLICABLE.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	$	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.

2011 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 2011 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 2011.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	THIS WORKSHEET IS NOT APPLICABLE.		$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ 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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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: 7/1/2011 Ending: 6/30/2012

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 [ ] 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: 7/1/2011 Ending: 6/30/2012

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	$	$ 437,161	4
5	50			1969	898,293	17,966	50	17,966		754,566	5
6				1968	395,224		25			395,224	6
7				1986	9,717		12			9,717	7
8				2010	5,818	388	15	388		1,164	8
	Improvement Type**										
9	MISC			1968	6,160	123	50	123		5,420	9
10	GARAGE			1972	2,491	50	50	50		1,993	10
11	FINISH BASEMENT			1973	6,343	127	50	127		4,948	11
12	WINDOW			1974	900	18	50	18		684	12
13	INSULATION			1976	21,986	440	50	440		15,830	13
14	ROOF			1980	16,049	321	50	321		10,271	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		20			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			11,869	21
22	IDPA AUDIT ADJUSTMENTS			1986	94,429		20			94,429	22
23	IDPA AUDIT ADJUSTMENTS			1989	146,038		20			146,038	23
24	DECORATING			1987	3,285		10			3,285	24
25	PARKING LOT			1988	19,937		10			19,937	25
26	FIRE ALARM SYSTEM			1990	37,956		10			37,956	26
27	NEW ROOF			1992	55,787		10			55,787	27
28	HOT WATER TANK			1992	3,295		10			3,295	28
29	BUILDING PAINTING			1993	7,336		5			7,336	29
30	ROOF REPAIRS			1993	434		10			434	30
31	WATER HEATER			1993	223		15			223	31
32	BOILER REPAIR			1993	1,415		10			1,415	32
33	CODE ALERT FIRE SYSTEM			1995	8,559		10			8,559	33
34	MISC			1997	3,013		10			3,013	34
35	VINYL FLOOR			1998	4,012		5			4,012	35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number ST JOSEPH NURSING HOME # 0005637 Report Period Beginning: 7/1/2011 Ending: 6/30/2012

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	CERAMIC FLOOR FOR NEW TUB	1999	$ 107	$ 5	20	$ 5	$	$ 63	37
38	CARPET ON WALLS	2000	2,668		5			2,668	38
39	METAMORA TELEPHONE SYSTEM	2000	7,337		10			7,337	39
40	TOMKAT ROOFING	2001	18,760	938	10	938		18,760	40
41	HOBERT CORP	2001	1,555	73	10	73		1,555	41
42	ASPHALT REPAIR	2002	2,900		8			2,900	42
43	75 GALLON 365M ASME WTR HTR	2006	5,225	523	10	523		2,876	43
44	ULTRA CARE 709 BED LAMINATE PANELS	2006	5,809	387	15	387		2,128	44
45	HOYER PROF PATIENT LIFT	2006	3,020	302	10	302		1,661	45
46	HOYER PROF VERTICAL PATIENT LIFT W/ SCALE	2006	4,249	424	10	424		2,333	46
47	CONCRETE SIDEWALK	2007	5,220	348	15	348		1,566	47
48	ROOFING	2007	20,986	2,098	10	2,098		9,442	48
49	FIRE DAMPERS	2007	13,100	874	15	874		3,932	49
50	BEDS (16)	2007	19,904	1,328	15	1,328		5,975	50
51	DOOR ALARM SYSTEM	2007	20,963	1,398	15	1,398		6,291	51
52	EQUIPMENT - NURSING SERVICE	2008	21,360	1,424	15	1,424		3,779	52
53	KITCHEN SUPPRESSION HOOD	2010	3,321	664	5	664		1,882	53
54	MODIFY GAS PIPING TO KITCHEN	2010	1,585	317	5	317		872	54
55	AIR CONDITIONING UNIT	2011	45,717	2,286	20	2,286		4,572	55
56	MEDICAL EQUIPMENT - DEFIBRILATOR	2011	1,562	156	10	156		312	56
57									57
58	LOUNGE REMODEL: WALL REPAIR AND PAINT	2012	1,100	110	10	110		110	58
59	LOUNGE REMODEL: FLOORING (CARPETING) INSTALL	2012	3,465	173	20	173		173	59
60	REHAB ROOM UPGRADE: PAINT, VINYL FLOOR AND								60
61	PURCHASE OF ADDITIONAL EQUIPMENT	2012	4,344	434	10	434		434	61
62	WATER HEATER AND BOOSTER	2012	4,817	241	20	241		241	62
63	ADJUSTMENT For PY Depreciation			(2,379)		(2,379)		34,158	63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,551,777	$ 40,858		$ 40,858	$	$ 2,257,654	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: 7/1/2011 Ending: 6/30/2012

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	$ 180,102	$ 10,338	$ 10,338	$		$ 138,019	71
72	Current Year Purchases	14,612	1,461	1,461			1,461	72
73	Fully Depreciated Assets	501,969					501,969	73
74								74
75	TOTALS	$ 696,683	$ 11,799	$ 11,799	$		$ 641,449	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	CHEVY CAPRICE & PICKUP	1987	$ 24,879	$	$	$		$ 24,879	76
77	NURSING HOME USE	MISC. OTHER	VARIOUS	9,476					9,476	77
78	NURSING HOME USE	2008 MED DUTY VEHICLE	2008	46,866	4,784	4,784			39,250	78
79										79
80	TOTALS			$ 81,221	$ 4,784	$ 4,784	$		$ 73,605	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)	$ 3,355,381	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)	$ 2,972,708	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: 7/1/2011 Ending: 6/30/2012

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? ☐ YES ☐ NO
   If NO, see instructions.

		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.	/2013	$
13.	/2014	$
14.	/2015	$

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: 7/1/2011 Ending: 6/30/2012

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: 7/1/2011 Ending: 6/30/2012

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		THIS WORKSHEET IS NOT APPLICABLE.			#VALUE!		5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$		$	$	#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: 7/1/2011 Ending: 6/30/2012

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/2012 (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	$ 313,653	$	1
2	Cash-Patient Deposits	6,457		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (254,825))	405,937		3
4	Supply Inventory (priced at COST)	37,794		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	338,282		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,104,059	$	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	914,716		15
16	Equipment, at Historical Cost	786,587		16
17	Accumulated Depreciation (book methods)	(2,972,708)		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)**	$ 349,973	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,454,032	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 718,985	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	15,912		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	113,171		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	266,154		36
37	Accrued Expenses	107,396		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,221,618	$	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)**	$ 1,221,618	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 232,336	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,453,954	$	48

***(See instructions.)**

Facility Name & ID Number ST JOSEPH NURSING HOME # 0005637 Report Period Beginning: 7/1/2011 Ending: 6/30/2012

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 32,207	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 32,207	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	200,129	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)**	$ 200,129	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)**	$ 232,336	24 *

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

Facility Name & ID Number ST JOSEPH NURSING HOME # 0005637 Report Period Beginning: 7/1/2011 Ending: 6/30/2012

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,065,591	1
2	Discounts and Allowances for all Levels	(1,185,369)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,880,222	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	558	12
13	Barber and Beauty Care	20,814	13
14	Non-Patient Meals	20,759	14
15	Telephone, Television and Radio	10	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients	16,596	18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	18,612	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 77,349	23
	D. Non-Operating Revenue		
24	Contributions	105,386	24
25	Interest and Other Investment Income***	(3,164)	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 102,222	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)**	$ 5,059,793	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,018,687	31
32	Health Care	2,311,963	32
33	General Administration	1,039,201	33
	B. Capital Expense		
34	Ownership	73,458	34
	C. Ancillary Expense		
35	Special Cost Centers	154,539	35
36	Provider Participation Fee	261,816	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,859,664	40
41	**Income before Income Taxes (line 30 minus line 40)****	200,129	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 200,129	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ 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: 7/1/2011 Ending: 6/30/2012

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	1,914	2,139	$ 61,301	$ 28.66	1
2	Assistant Director of Nursing					2
3	Registered Nurses	14,059	15,301	408,427	26.69	3
4	Licensed Practical Nurses	19,670	22,067	474,264	21.49	4
5	CNAs & Orderlies	63,915	75,534	893,379	11.83	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	4,047	4,227	52,395	12.40	10
11	Social Service Workers	5,337	5,397	93,511	17.33	11
12	Dietician					12
13	Food Service Supervisor	1,882	2,126	46,081	21.67	13
14	Head Cook	5,798	6,248	66,868	10.70	14
15	Cook Helpers/Assistants	3,328	3,638	33,625	9.24	15
16	Dishwashers	17,621	17,881	179,053	10.01	16
17	Maintenance Workers	4,034	4,687	79,642	16.99	17
18	Housekeepers	8,648	10,017	90,366	9.02	18
19	Laundry	8,548	10,017	104,227	10.41	19
20	Administrator	2,080	2,160	87,567	40.54	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,080	2,160	37,567	17.39	23
24	Clerical	8,400	9,763	124,221	12.72	24
25	Vocational Instruction					25
26	Academic Instruction	2,137	2,137	26,876	12.58	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	1,800	1,836	21,387	11.65	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	175,298	197,335	$ 2,880,757 *	$ 14.60	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		$ 4,453		35
36	Medical Director				36
37	Medical Records Consultant		2,262		37
38	Nurse Consultant				38
39	Pharmacist Consultant		5,334		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		1,160		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 13,209		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 1,939		50
51	Licensed Practical Nurses		14,517		51
52	Certified Nurse Assistants/Aides		4,126		52
53	TOTAL (lines 50 - 52)		$ 20,582		53

Facility Name & ID Number ST JOSEPH NURSING HOME # 0005637 Report Period Beginning: 7/1/2011 Ending: 6/30/2012

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
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
Brown Smith Wallace, LLC	Auditor	$ 27,840
Provena Senior Services	Healthcare Management	21,183
Facet Technologies	Medical Supplier	7,772
Walker Phillips	Medicare Cost Report	4,290
CBIZ Valuation Group	Asset Valuation	2,730
Krones	Payroll Provider	928
CMS L	Laboratory Charges	464
Alliance Benefit	Nursing Home Org. - Fees	430
Miller, Hall & Trigg	Attorney/Legal	247
National Elevator	Elevator Maintenance	155
Medifax-Edi LLC	Public Aid Software	26
Procare (refund)	O2 Vendor - Refund	(18)

TOTAL (agree to Schedule V, line 19, column 3)
(If total legal fees exceed $5,000, attach copy of invoices.) $ 66,047

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 106,513
Unemployment Compensation Insurance	36,956
FICA Taxes	193,270
Employee Health Insurance	208,993
Employee Meals	1,100
Illinois Municipal Retirement Fund (IMRF)*	
Employee Incentives	12,184
Less: Sister's Maintenance Adjustment	(6,346)
TOTAL (agree to Schedule V, line 22, col.8)	$ 552,670

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	16,818
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
Licenses and Fees	14,196
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 31,014

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ NONE
In-State Travel	2,667
Seminar Expense	6,607
Vehicle Maintenance and Gas	6,722
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 15,996

**See instructions.

Facility Name & ID Number ST JOSEPH NURSING HOME # 0005637 Report Period Beginning: 7/1/2011 Ending: 6/30/2012

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? **15 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **66,878** 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. $ **261,816**
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. $ **20,759**

(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.

Facility Name & ID Number ST JOSEPH NURSING HOME # 0005637 Report Period Beginning: 7/1/2011 Ending: 6/30/2012

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		$		$	$	$	$	$	$	$	$	$

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	29,116		
	Meals per day	3	87,348	89.86%
Meals provided to	Number of Sisters	9		
Sisters (non-patient):	Meals per day	3		
	Days per year	365	9,855	10.14%
	Total Meals Served		**97,203**	**100.00%**

Adjustments for Sisters' Maintenance:

Sisters' portion of dietary and food cost:	Dietary cost	$ 39,076	*From page 3, Line 1, Col. 4*	
	Sisters' percentage	10.14%	*From calculation above*	
	Sisters' Portion of Dietary Cost	**$ 3,962**	***Adjustment: To Line 1, Schedule V***	
	Food cost	$ 211,285	*From page 3, Line 2, Col. 4*	
	Sisters' percentage	10.14%	*From calculation above*	
	Sisters' Portion of Food Cost	**$ 21,421**	***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	$ 114,222	*From page 3, Line 5, Col. 4*
	Sisters' percentage	3.70%	*From calculation above*
	Sisters' Portion of Heat and Other Utilities	**$ 4,222**	***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	$ 322,569		*From page 3, Line 1, Col. 1*
Sisters' percentage	10.14%		*From calculation above*
Salaries Applicable to Sister's Meals		$ 32,704	
Total Salaries	$ 2,880,757		*From page 4, Line 45, Col. 1*
Employee Benefits	$ 559,016		*From page 3, Line 22, Col. 4*
Employee benefits ratio		19.41%	
Employee Benefits Applicable to Sisters' Meals		$ 6,346	***Adjustment: To Line 22, Schedule V***

Total Adjustments for Sisters' Portion of Costs	**$ 35,952**

ST. JOSEPH NURSING HOME
Schedule V - Detail of Line 14 (Total Exceeds $2,000)
Reporting Period Beginning JULY 1, 2010 and Ending JUNE 30, 2011

V--14.3 Program Transportation

Date	Name	Mileage	Dollar	Description
8/30/2011	John Murphy	51	$ 26	Taking Resident to their Doctor Appt in Spring Valley, IL
8/30/2011	John Murphy	59	$ 30	Taking Resident to their Doctor Appt in Peoria, IL
8/30/2011	John Murphy	59	$ 30	Taking Resident to their Doctor Appt in Peoria, IL
6/15/2012	John Murphy	52	$ 26	Taking Resident to their Eye Appt in Peoria, IL
7/29/2011	Freedom Oil CO		$ 403	Gas for transporting Residents to doc appt
8/31/2011	Freedom Oil CO		$ 377	Gas for transporting Residents to doc appt
9/27/2011	Freedom Oil CO		$ 529	Gas for transporting Residents to doc appt
12/30/2011	Freedom Oil CO		$ 537	Gas for transporting Residents to doc appt
11/21/2011	Advanced Med Trans.		$ 80	Transporting Resident to Doc. Appt
11/21/2011	Advanced Med Trans.		$ 80	Transporting Resident to Doc. Appt
11/26/2011	Freedom Oil CO		$ 413	Gas for transporting Residents to doc appt
11/29/2011	Freedom Oil CO		$ 366	Gas for transporting Residents to doc appt
1/31/2012	Freedom Oil CO		$ 244	Gas for transporting Residents to doc appt
2/14/2012	St. Margaret Paratran		$ 15	Transporting new resident to SJH
2/29/2012	Freedom Oil CO		$ 388	Gas for transporting Residents to doc appt
3/28/2012	Freedom Oil CO		$ 457	Gas for transporting Residents to doc appt
4/24/2012	Freedom Oil CO		$ 502	Gas for transporting Residents to doc appt
5/30/2012	Freedom Oil CO		$ 579	Gas for transporting Residents to doc appt
6/26/2012	Freedom Oil CO		$ 466	Gas for transporting Residents to doc appt
	Subtotal		**5,547.00**	

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

Date	Name	Mileage	Dollar	Description
8/23/2011	Maggie Hovey	214	$ 107.00	Director of Nursing Meeting at Mokena, IL
8/23/2011	Lisa Helms	162	$ 81.00	Management Meeting at Aurora, IL
8/23/2011	Lisa Helms	158	$ 79.00	Management Meeting at Joliet, IL
8/30/2011	Zaida Murphy	50	$ 25.00	Taking Employee to IWIRC due to an incident
9/8/2011	Maggie Hovey	114	$ 107.00	Director of Nursing Meeting at Bolingbrook, IL
9/9/2011	Maggie Hovey	204	$ 102.00	Management Meeting at Mokena, IL
9/13/2011	Maggie Hovey	50	$ 25.00	Taking Employee to IWRC due to an incident
9/21/2011	Maggie Hovey	184	$ 92.00	Management Meeting at Joliet, IL
9/27/2011	Valerie Grimes	75	$ 37.50	Travel to Peoria, IL to research prices for Room Remodeling
10/6/2011	Valerie Grimes	66	$ 33.00	Travel to Peoria, IL to pick up supplies to remodel Rooms.
10/12/2011	Valerie Grimes	65	$ 32.50	Travel to Peoria, IL for supplies for the Donor's Open House
9/22/2011	Harriet Cowell	86	$ 43.00	Travel to visit past residents in the County-Marketing
10/12/2011	Harriet Cowell	55	$ 27.50	Marketing Meeting at Tawwell Senior Fest
10/18/2011	Lisa Helms	236	$ 118.00	Management Meeting at Oakbrook, IL
9/30/2011	Lisa Helms	174	$ 87.00	Management Meeting at Mokena, IL
11/2/2011	Harriet Cowell	55	$ 27.50	Hospital visits in Peoria, IL
12/9/2011	Zaida Murphy	50	$ 25.00	Taking Employee to IWIRC due to an incident
1/17/2012	Leah Gray		$ 99.40	Training Meeting in
2/14/2012	Maggie Hovey	204	$ 102.00	Management Meeting in Bolingbrook, IL
4/17/2012	Lisa Helms	206	$ 113.30	Management Meeting in Rockford, IL
4/27/2012	Lisa Helms	218	$ 119.90	Management Meeting in Northlake, IL
5/2/2012	Lisa Helms	234	$ 128.70	Management Meeting in Chicago, IL
5/2/2012	Lisa Helms		$ 207.55	Embassy Suites in Chicago, IL/Hotel Room
5/3/2012	Lisa Helms		$ 21.00	Navy Pier Parking in Chicago, IL/Parking
5/4/2012	Lisa Helms		$ 74.50	Embassy Suites in Chicago, IL/Hotel Room
5/3/2012	Maggie Hovey	68	$ 37.50	Management Meeting in Edwards, IL
5/10/2012	Maggie Hovey	56	$ 30.80	Management Meeting in Peoria, IL
5/18/2012	Maggie Hovey	62	$ 34.10	Management Meeting in Peoria, IL
5/22/2012	Maggie Hovey	188	$ 103.40	Management Meeting in Joliet, IL
6/4/2012	Lisa Helms	176	$ 96.80	Management Meeting in Mokena, IL
6/22/2012	Lisa Helms	198	$ 108.90	Management Meeting in Rockford, IL
6/11/2012	Maggie Hovey	206	$ 113.30	Director of Nursing Meeting in Bolingbrook, IL
6/12/2012	Maggie Hovey	212	$ 116.60	Management Meeting in Mokena, IL
	Travel	**410039-00**	**2,556.75**	

8/2/2011	Katrina Thompson		$	25.00	Registration cost for CIHIMA meeting
8/16/2011	American Red Cross		$	243.00	Adult & Child CPR/AED class
4/11/2012	American Red Cross		$	108.00	Adult & Child CPR/AED class
	Education	**410219-00**		**376.00**	
8/4/2011	American Express		$	163.00	Amer. Red Cross Handbook & Kit
9/8/2011	Alzheimer's Assoc.		$	128.60	In-Service Fee & Mileage
11/21/2011	Life Services Network		$	5,701.02	LSN membership dues
1/5/2012	Eldercare Comm.		$	100.00	Abuse Prevent/Protect DVD
4/16/2012	American Red Cross		$	138.00	CPR Class Equipment Rental
	Education	**600119-00**		**6,230.62**	
8/11/2011	Petty Cash		$	10.01	Gas for Harriet Cowell-marketing
8/13/2011	Larry Racobs		$	379.47	Purchasing gas blower- tractor parts
9/16/2011	Lacon Motors		$	55.15	Servicing the Chevrolet Cavalier
10/26/2011	Lacon Motors		$	41.20	Servicing the Dodge Ram Van
11/8/2011	O'Reilly Auto Parts		$	66.97	Rotors & Pads for Chevrolet Cavalier
11/8/2011	Lacon Motors		$	202.07	Parts for Parts to repair truck
11/9/2011	O'Reilly Auto Parts		$	91.56	Battery, Brake Cleaner for Chevy Cavalier
12/29/2011	Small Engine Wareho		$	35.20	Repair lawn tractor
1/19/2012	Cash Receipts		$	(250.00)	Mary Gorman trip to Peoria with Fr. Gorman Reimbursing Nursing for Gas
2/3/2012	Lisa Helms	188	$	94.00	Meeting in Aurora, IL
1/27/2012	Lisa Helms	176	$	88.00	Meeting in Mokena, IL
2/9/2012	Petty Cash		$	20.00	Van state inspection
2/21/2012	Lisa Helms	152	$	76.00	Meeting in Joliet, IL
3/16/2012	Danny's Auto Repair		$	125.81	Servicing the van
3/16/2012	Danny's Auto Repair		$	56.84	Servicing the Chevrolet Cavalier
5/4/2012	Morton Body & Equip		$	173.00	Repair lift on van
6/5/2012	John Murphy		$	20.50	Truck Inspection Test
	Vehicle Maint. & Gas, Etc.	**510019-00**		**1,285.78**	
		Subtotal		**10,449.15**	

ST. JOSEPH NURSING HOME
List of Board of Directors
Reporting Period Beginning JULY 1, 2011 and Ending JUNE 30, 2012

Name	Title
Sister Loretta Matas	President of the Board
Sister Rudolfia Petrik	Secretary/Treasurer
Sister M. Adriana Zdila	Board Member
Sister M. Justina Delonga	Board Member
Sister M. Agnes Stetson	Board Member
Sister M. Michael Fox	Board Member

Non Board Member - Attends Meetings

Lisa Helms	Administrator