

		FOR BHF USE					

LL1

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

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

I. IDPH License ID Number: 0005520

Facility Name: Mount St Joseph

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

County: LAKE

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

HFS ID Number:

Date of Initial License for Current Owners: 1947

Type of Ownership:

☒ VOLUNTARY,NON-PROFIT
☒ Charitable Corp.
☐ Trust
IRS Exemption Code

☐ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☐ "Sub-S" Corp.
☐ Limited Liability Co.
☐ Trust
☐ Other
☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

In the event there are further questions about this report, please contact:
Name: Robert JJ Gaudio Telephone Number: 847-438-5050 EXT 108
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) 10/22/12
(Date)

(Type or Print Name) Sister Anna Maria Bilotta

(Title) Exective Director

Paid
Preparer

(Signed)
(Date)

(Print Name
and Title)

(Firm Name
& Address)

(Telephone) () Fax # ()

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

Facility Name & ID Number Mount St Joseph# 0005520 Report Period Beginning: 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 _____

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

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	41,946	723		42,669	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	41,946	723		42,669	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 88.56%

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?

YESG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☒ NO ☐

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☒ NO ☐

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

Date started 1947

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date _____ NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☐ NO ☒ If YES, enter number
of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED
CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 6/30/2012 Fiscal Year: 6/30/2012

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

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						
		1	2	3	4	5	6	7	8	9	10
	A. General Services										
1	Dietary	142,759		8,502	151,261		151,261	(15,126)	136,135		1
2	Food Purchase		80,776		80,776		80,776	(8,078)	72,698		2
3	Housekeeping	414,992			414,992		414,992		414,992		3
4	Laundry	36,029	565		36,594		36,594		36,594		4
5	Heat and Other Utilities			262,657	262,657		262,657	(10,506)	252,151		5
6	Maintenance	251,009	34,429		285,438		285,438		285,438		6
7	Other (specify):*										7
8	TOTAL General Services	844,789	115,770	271,159	1,231,718		1,231,718	(33,710)	1,198,008		8
	B. Health Care and Programs										
9	Medical Director	24,022			24,022		24,022		24,022		9
10	Nursing and Medical Records	2,179,365	58,943	33,508	2,271,816	(24,820)	2,246,996		2,246,996		10
10a	Therapy	58,397			58,397		58,397		58,397		10a
11	Activities										11
12	Social Services	12,232		5,088	17,320		17,320		17,320		12
13	CNA Training					24,820	24,820		24,820		13
14	Program Transportation			46,032	46,032		46,032		46,032		14
15	Other (specify):* DAY TRAINING	203,491	13,619	460,977	678,087		678,087	(643,366)	34,721		15
16	TOTAL Health Care and Programs	2,477,507	72,562	545,605	3,095,674		3,095,674	(643,366)	2,452,308		16
	C. General Administration										
17	Administrative	87,750	14,530		102,280	(12,621)	89,659		89,659		17
18	Directors Fees										18
19	Professional Services			90,456	90,456		90,456		90,456		19
20	Dues, Fees, Subscriptions & Promotions			11,931	11,931		11,931		11,931		20
21	Clerical & General Office Expenses	218,399	13,559		231,958		231,958		231,958		21
22	Employee Benefits & Payroll Taxes			536,517	536,517		536,517	(34,721)	501,796		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,101	2,101		2,101		2,101		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			99,830	99,830		99,830		99,830		26
27	Other (specify):*										27
28	TOTAL General Administration	306,149	28,089	740,835	1,075,073	(12,621)	1,062,452	(34,721)	1,027,731		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,628,445	216,421	1,557,599	5,402,465	(12,621)	5,389,844	(711,797)	4,678,047		29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			554,999	554,999		554,999	81,009	636,008			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			180,000	180,000		180,000	(180,000)				34
35	Rent-Equipment & Vehicles					12,621	12,621		12,621			35
36	Other (specify):*											36
37	TOTAL Ownership			734,999	734,999	12,621	747,620	(98,991)	648,629			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			345,458	345,458		345,458		345,458			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			345,458	345,458		345,458		345,458			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	3,628,445	216,421	2,638,056	6,482,922		6,482,922	(810,788)	5,672,134			45

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

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs	(23,204)	L 1 & 2		3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(34,721)	L22		14
15	Non-Care Related Owner's Transactions	(643,366)	L15		15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(10,506)	L5		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (711,797)		\$	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	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense	(98,991)	VII L14	33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (98,991)		36
(sum of SUBTOTALS				
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (810,788)		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	2	3	4	
		Yes	No	Amount	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

Mount St Joseph

ID# 0005520

Report Period Beginning: 7/1/2011

Ending: 6/30/2012

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1		\$		1
2				2
3	GOVERNMENTAL SPONSORED PROGRAMS	(23,204)	L1 & L2	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23	DEVELOPMENTAL DAY TRAINING	(643,366)	L15	23
24	PAYROLL TAX DAY TRAINING	(34,721)	L22	24
25				25
26				26
27				27
28				28
29	UTILITIES	(10,506)	L5	29
30				30
31				31
32				32

33				33
34	RELATED ORGANIZATIONAL COSTS	(98,991)	VII L14	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	(810,788)		49

Summary B

6/30/2012

[illegible]

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
Daughters of St Mary of Providence	100					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V		Rent	\$ (180,000)	Daughters of St Mary of Providence	100.00%	\$	\$ 180,000	1
2	V		Depreciation	81,009	Daughters of St Mary of Providence	100.00%		(81,009)	2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ (98,991)			\$	\$ * 98,991	14

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

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Sister Anna Maria Bilotta	SUPERIOR	C.E.O.	0.00	0	84	100.00	STIPEND	\$ 58,500	L17C1	1
2	Sister Esther Leroux	ADMINISTRATOR	DIRECTOR	0.00	0	84	100.00	STIPEND	29,250	L17C1	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 87,750		13

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

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

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

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

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2011 report.		\$	N/A		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$			2
3. Under or (over) accrual (line 2 minus line 1).		\$			3
4. Real Estate Tax accrual used for 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.)		\$	TAX EXEMPT		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$			7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2007		8	
		2008		9	
		2009		10	
		2010		11	
		2011		12	
				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	Mount St Joseph	COUNTY	LAKE
---------------	-----------------	--------	------

FACILITY IDPH LICENSE NUMBER 0005520

CONTACT PERSON REGARDING THIS REPORT

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 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)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.		\$	\$
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$	\$

B. Real Estate Tax Cost Allocations

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

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home.
(Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 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.**

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 168,131

B. General Construction Type: Exterior Brick Frame Brick

Number of Stories 2

C. Does the Operating Entity?

☐ (a) Own the Facility

☒ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☐ (c) Rent equipment from Completely Unrelated Organization.

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

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

DEVELOPMENTAL TRAINING 1,010 SQUARE FEET

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:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

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

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	132			1969	\$ 5,007,009	\$ 464,671		\$ 464,671	\$	\$ 8,904,214
5										
6				1990	2,361,653	78,720		78,720		1,771,202
7				1990	68,729	2,289		2,289		51,523
8										
	Improvement Type**									
9	LAND DEVELOPMENT - PRIOR YEARS			1993	29,005					
10				1994	93,489					
11				1995	44,713					
12				1996	18,082					
13				1997	42,570					
14				1998	17,423					
15				1999	21,853					
16				2001	4,700					
17				2005	22,748					
18				2006	12,917					
19				2007	82,454					
20	BUILDINGIMPROVEMENT - PRIOR YEARS			1991	74,205					
21				1992	90,293					
22				1993	180,181					
23				1994	178,251					
24				1995	231,228					
25				1996	82,875					
26				1997	71,814					
27				1998	116,448					
28				1999	121,823					
29				2000	37,015					
30				2001	76,812					
31				2002	112,086					
32				2003	250,123					
33				2004	402,099					
34				2005	802,449					
35				2006	1,003,267					
36				2007	699,546					

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Mount St Joseph

0005520

Report Period Beginning:

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	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	LAND IMPROVEMENTS		\$	\$		\$	\$	\$	37
38	Prior Year	2008	156,512						38
39	CEMETERY MEMORIALS	3/1/2009	3,409						39
40	STUMP REMOVAL	3/1/2009	3,500						40
41	TREE REMOVAL	4/1/2009	2,850						41
42	PAVING	6/1/2009	148,000						42
43	6 SANDSTONE BASES & CROSSES	11/24/2010	2,922						43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51	BUILDING IMPROVEMENTS								51
52	Prior Year	2008	2,220,145						52
53	PUMPHOUSE RELOCATE POWER	4/8/2009	10,458						53
54	KITCHEN GAS METER & WATER PUMP REPAIR	4/8/2009	8,290						54
55	ATTIC ALUMINUM DOOR	4/8/2009	2,372						55
56	LIVINGROOM 2 CHANDLIERS	4/8/2009	2,024						56
57	DRY SYSTEM CLEANING	12/8/2009	6,804						57
58	KITCHEN FOUNDATION REPAIR	1/9/2009	28,390						58
59	ATTIC ELECTRIC HEATERS	1/9/2009	8,290						59
60	WINDOW TREATMENTS & DRAPES	1/9/2009	26,180						60
61	PASSAGEWAY HEATER & TUCK POINTING	2/9/2009	26,760						61
62	POOL ROOM PAINT	3/9/2009	15,490						62
63	FIRE ALARM PANEL	3/9/2009	19,000						63
64	GAS VALVES & PUMP	3/9/2009	17,785						64
65	DRAIN TILE SERVICES	3/9/2009	11,844						65
66	THERAPY COMPRESSOR	5/9/2009	11,262						66
67	MARCELLINA HALL REMOVE FIRE ALARM	5/9/2009	54,720						67
68	ST. ROSE ROOF	6/9/2009	26,815						68
69	FIRE ALARM - ST ALOYSIU	7/16/2009	41,200						69
70	TOTAL (lines 4 thru 69)		\$ 15,212,882	\$ 545,680		\$ 545,680	\$	\$ 10,726,939	70

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

Facility Name & ID Number Mount St Joseph

0005520

Report Period Beginning:

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	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 15,212,882	\$ 545,680		\$ 545,680	\$	\$ 10,726,939	1
2	BUILDING IMPROVEMENTS - Cont'd								2
3	PEWS FOR CHAPEL	8/24/2009	10,225						3
4	DOOR LOCKS AND RELATED	9/14/2009	11,425						4
5	RANE BATHING SYSTEM REC	11/30/2009	9,800						5
6	WINDOW DRAPERIES & HARD	12/21/2009	5,938						6
7	SMT HEALTH SYSTEMS FULL	3/3/2010	13,992						7
8	ANGEL GUARDIAN FLOOR TI	3/8/2010	6,985						8
9	NEW FIRE ALARM FOR ST J	3/15/2010	36,000						9
10	SMT HEALTH SYSTEM FULL	3/16/2010	6,990						10
11	HEAT EXCHANGER FOR ADMIN BUILDING	5/10/2010	8,960						11
12	FIRE ALARM SYSTEM LAUNDRY	5/19/2010	17,000						12
13	FIRE ALARM SYSTEM - CHAPEL	5/19/2010	18,000						13
14	PASSAGEWAY REMODEL	6/30/2010	1,400,592						14
15	ADMIN BUILDING ROOF(Contracted Total)	6/21/2010	39,740						15
16	CARPET IN POOL REHAB AREA	3/10/2011	6,995						16
17	CERAMIC FLOR TILE IN NEW TUB ROOM	3/10/2011	1,498						17
18	ADMIN BUILDING REFURBISHMENT	3/28/2011	30,000						18
19	COPY ROOM & STONE TOPS	5/2/2011	14,400						19
20	ADMIN BUILDING REFURB. - PHASE II - (Contracted Total)	5/4/2011	30,000						20
21	ADMIN BUILDING REFURB. - PHASE III - (Contracted Total)	5/4/2011	17,000						21
22	ADMIN BUILDING REFURB. - PHASE IV - (Contracted Total)	5/31/2011	75,558						22
23	ADMIN BUILDING REFURB. - PHASE V - (Contracted Total)	6/8/2011	50,372						23
24	ADMIN BUILDING REFURB. - PHASE VI - (Contracted Total)	6/13/2011	19,800						24
25	ADMIN BUILDING REFURB. - PHASE VII - (Contracted Total)	6/20/2011	27,730						25
26	ADMIN BUILDING REFURB. - PHASE VIII - (Contracted Total)	6/20/2011	21,453						26
27	ADMIN BUILDING REMODEL - ELECTRIC	6/20/2011	2,185						27
28	ADMIN BUILDING REMODEL - WINDOWS	6/30/2011	8,417						28
29	BEATTY DECORATING - REPAIR & PAINTING	7/7/2011	8,417						29
30	REPAVE ROAD	8/3/2011	128,900						30
31	FOYER RADIUS AND STONE CAP	8/1/2011	1,500						31
32	ROOFING AND PAINTING FOR THERAPY CENTER	10/26/2011	2,785						32
33	ADDITIONAL PAINTING FOR THERAPY CENTER	10/26/2011	3,180						33
34	TOTAL (lines 1 thru 33)		\$ 17,248,718	\$ 545,680		\$ 545,680	\$	\$ 10,726,939	34

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

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	
1	Totals from Page 12B, Carried Forward		\$ 17,248,718	\$ 545,680		\$ 545,680	\$	\$ 10,726,939	1
2	BUILDING IMPROVEMENTS - Cont'd								2
3	THERAPY CENTER ROOFING REPAIRS (ADDT'L)	10/26/2011	3,169						3
4	EXIT LIGHTS FOR SACRED HEART	6/29/2012	1,780						4
5	GAZEBO RENOVATION	6/30/2012	65,100						5
6	SACRED HEART RENOVATION	6/30/2012	3,323,620						6
7	REPAVE COMPLEX ROADS	6/30/2012	147,500						7
8	ADMINISTRATOIN BLDG CABINETRY	7/21/2011	4,700						8
9	GAZEBO LIGHTING & ELECTRICAL UPDATE	8/5/2011	6,312						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	TOTAL (lines 1 thru 33)		\$ 20,800,899	\$ 545,680		\$ 545,680	\$	\$ 10,726,939	34

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

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	\$1,640,079	\$45,806	\$45,806	\$		\$1,371,351	71
72	Current Year Purchases	27,852						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$1,667,931	\$45,806	\$45,806	\$		\$1,371,351	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	Residential Transport	2002 Ford Van	2002	\$23,334	\$1,750	\$1,750	\$		\$23,334	76
77										77
78										78
79										79
80	TOTALS			\$23,334	\$1,750	\$1,750	\$		\$23,334	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)	\$22,500,164	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$593,236	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$593,236	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)	\$12,121,624	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	FARM EQUIPMENT	\$40,316	\$	\$40,316	86
87	VEHICLES	348,131	29,670	234,565	87
88	NON-CARE	1,076,857	13,102	1,041,081	88
89					89
90					90
91	TOTALS	\$1,465,304	\$42,772	\$1,315,962	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.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

**

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

9. Option to Buy:
- ☐ YES
- ☐ NO
- Terms:
-
- *

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

15. Is Movable equipment rental included in building rental?
- ☐ YES
- ☒ NO

16. Rental Amount for movable equipment:
- \$ 12,621
- Description:
-
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning

Ending

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

	Fiscal Year Ending	Annual Rent
12.		\$
13.		\$
14.		\$

* 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.

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
☐ 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 CNA40

3. CLINICAL PORTION:

IN-HOUSE PROGRAM☒
IN OTHER FACILITY☐
HOURS PER CNA80

B. EXPENSES

C. CONTRACTUAL INCOME

ALLOCATION OF COSTS (d)

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

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)		9,180		9,180
4	Clinical Wages (b)		15,640		15,640
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 24,820	\$	\$ 24,820
10	SUM OF line 9, col. 1 and 2 (e)	\$	24,820		

COMPLETED	
1. From this facility	27
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	27

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

		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	L9C1	visits	24,022					24,022	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			\$ 24,022		\$	\$		\$ 24,022	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.

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	\$ 4,104,257	\$ 4,104,257	1
2	Cash-Patient Deposits	67,371	67,371	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	692,316	692,316	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	168,005	168,005	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Interest in Trust</u>	13,995,434	13,995,434	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 19,027,383	\$ 19,027,383	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	50,118	50,118	12
13	Land		8,000	13
14	Buildings, at Historical Cost		7,437,391	14
15	Leasehold Improvements, at Historical Cost	9,912,311	15,090,776	15
16	Equipment, at Historical Cost		3,003,419	16
17	Accumulated Depreciation (book methods)		(12,053,339)	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)	\$ 9,962,429	\$ 13,536,365	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 28,989,812	\$ 32,563,748	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 478,386	\$ 478,386	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	67,371	67,371	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	325,182	325,182	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 870,939	\$ 870,939	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)	\$ 870,939	\$ 870,939	46
47	TOTAL EQUITY(page 18, line 24)	\$ 28,118,873	\$ 31,692,809	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 28,989,812	\$ 32,563,748	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 10,512,810	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 10,512,810	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	17,606,063	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)	\$ 17,606,063	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)	\$ 28,118,873	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Mount St Joseph# 0005520Report Period Beginning: 7/1/2011Ending: 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.

	1		2
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 5,787,013	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,787,013	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions	17,587,374	24
25	Interest and Other Investment Income***	25,284	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 17,612,658	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	<u>Developmental Day Training</u>	689,314	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 689,314	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 24,088,985	30

	1		2
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,231,718	31
32	Health Care	3,095,674	32
33	General Administration	1,062,452	33
	B. Capital Expense		
34	Ownership	747,620	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	345,458	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,482,922	40
41	Income before Income Taxes (line 30 minus line 40)**	17,606,063	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 17,606,063	43

	1		2
	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 4,483,417	44
45	Private Pay - Net Inpatient Revenue	100,800	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) <u>SSA / SSI</u>	1,202,796	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,787,013	49

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

** Does this agree with taxable income (loss) per Federal Income

Tax Return? Yes If not, please attach a reconciliation.

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

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

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing			\$	\$	1
2	Assistant Director of Nursing					2
3	Registered Nurses	15,053	15,961	368,862	23.11	3
4	Licensed Practical Nurses	7,571	8,028	144,988	18.06	4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	27	29	250	8.62	8
9	Activity Director	3,016	3,198	58,147	18.18	9
10	Activity Assistants					10
11	Social Service Workers	590	626	12,232	19.54	11
12	Dietician					12
13	Food Service Supervisor	865	917	11,773	12.84	13
14	Head Cook	5,148	5,458	72,872	13.35	14
15	Cook Helpers/Assistants	5,337	5,659	58,114	10.27	15
16	Dishwashers					16
17	Maintenance Workers	14,586	15,466	251,009	16.23	17
18	Housekeepers	43,294	45,906	414,992	9.04	18
19	Laundry	3,997	4,239	36,029	8.50	19
20	Administrator	3,705	3,928	62,854	16.00	20
21	Assistant Administrator	4,428	4,695	54,000	11.50	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,957	12,679	189,294	14.93	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director	1,295	1,373	24,022	17.50	27
28	Qualified MR Prof. (QMRP)	8,513	9,027	154,364	17.10	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	130,628	138,511	1,511,152	10.91	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) DAY TRAINING	17,196	18,234	203,491	11.16	33
34	TOTAL (lines 1 - 33)	277,206	293,934	\$ 3,628,445 *	\$ 12.34	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	170	\$ 8,502	L1 C3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	68	5,088	L10 C3	45
46	Other(specify) - Dentist	32	1,593	L10 C3	46
47	Psychiatrist	0	0	L10 C3	47
48	Podiatrist	18	1,080	L10 C3	48
49	TOTAL (lines 35 - 48)	288	\$ 16,263		49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description		Amount	Description	Amount	
<u>Sr. Anna Maria Bilotta</u>	<u>SUPERIOR</u>		\$ 58,500	Workers' Compensation Insurance		\$ 157,159	IDPH License Fee	\$	
				Unemployment Compensation Insurance		0	Advertising: Employee Recruitment		
				FICA Taxes		280,261	Health Care Worker Background Check		
<u>Sr. Esther Leroux</u>	<u>ADMINISTRATOR</u>		29,250	Employee Health Insurance		828	(Indicate # of checks performed _____)		
				Employee Meals		0	<u>Patient Background Checks</u>		
				Illinois Municipal Retirement Fund (IMRF)*		0	<u>Licenses & Fees</u>	8,428	
				<u>Employee Pension</u>		98,269	<u>Dues & Subcriptions</u>	3,503	
				<u>Day Training Payroll Tax</u>		(34,721)			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)									
B. Administrative - Other									
Description			Amount						
			\$						
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL (agree to Schedule V, line 22, col.8)		\$ 501,796	TOTAL (agree to Sch. V, line 20, col. 8) \$ 11,931		
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount	
<u>BIK & CO.</u>	<u>AUDITORS</u>		\$ 31,500			\$	Out-of-State Travel	\$	
<u>MICHAEL SULLIVAN</u>	<u>ACCOUNTING</u>		40,713						
<u>AMCHECK</u>	<u>PAYROLL</u>		18,243				In-State Travel		
							Seminar Expense	2,101	
							Entertainment Expense	()	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)				TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8) \$ 2,101		

*** Attach copy of IMRF notifications**

****See instructions.**

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?
If YES, give association name and amount.

NO
- (3)

Did the nursing home make political contributions or payments to a political action organization?
If YES, have these costs been properly adjusted out of the cost report?

NO
- (4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?
If YES, what is the capacity?

NO
- (5)

Have you properly capitalized all major repairs and equipment purchases?
What was the average life used for new equipment added during this period?

YES
10 YRS
- (6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$ 33,728 Line L 10
- (7)

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

YES
- (8)

Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease.

NO
- (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)?
If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

YES NO X
- (11)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.
This amount is to be recorded on line 42 of Schedule V.

\$ 345,458
- (12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?
If YES, attach an explanation of the allocation.

NO

- (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?
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.

YES
- (15)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.
Has any meal income been offset against related costs?

\$ N/A
Indicate the amount. \$
- (16)

Travel and Transportation

a.

Are there costs included for out-of-state travel?
If YES, attach a complete explanation.

NO

b.

Do you have a separate contract with the Department to provide medical transportation for residents?
If YES, please indicate the amount of income earned from such a program during this reporting period.

YES 838

c.

What percent of all travel expense relates to transportation of nurses and patients?

10%

d.

Have vehicle usage logs been maintained?

YES

e.

Are all vehicles stored at the nursing home during the night and all other times when not in use?

YES

f.

Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

g.

Does the facility transport residents to and from day training?
Indicate the amount of income earned from providing such transportation during this reporting period.

YES
\$ 0

(17)

Has an audit been performed by an independent certified public accounting firm?
Firm Name:

YES

(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?
Attach invoices and a summary of services for all architect and appraisal fees.

N/A

V. COST CENTER EXPENSES RECLASSIFICATION PAGE 3

FROM	V. LINE 10	-24,820
TO	V. LINE 13	24,820
	TO RECLASSIFY NURSE AIDE TRAINING	
FROM	V. LINE 17	-12,621
TO	V. LINE 35	12,621
	TO RECLASSIFY RENT-EQUIPMENT	

LINE 15 PAGE 3

DAY TRAINING	SALARIES	378,370	
DAY TRAINING	SUPPLIES	13,619	
DAY TRAINING	BENEFITS	25,104	
DAY TRAINING	PROFESSIONAL FEE	6,836	
DAY TRAINING	OCCUPANCY	72,952	
DAY TRAINING	TRANSPORT	61,908	
DAY TRAINING	RENT	20,700	
DAY TRAINING	DEPRECIATION	63,877	
DAY TRAINING	EDUCATIONAL	0	
	SUB-TOTAL	251,377	643,366
DAY TRAINING	P/R TAX	LINE 22 PAGE 3	34,721
	TOTAL		678,087

VI. ADJUSTMENT DETAIL PAGE 5

NON-ALLOWABLE EXPENSES

DIETARY	VI. LINE 1	151,261 X .10 =	-15,126	
FOOD PURCHASE	V. LINE 2	80,776 X .10 =	-8,078	-23,204
DEPRECIATION	V. LINE 30			0
DAY TRAINING	V. LINE 15			-643,366
DAY TRAINING P/R TAX	V. LINE 22			-34,721
UTILITIES	V. LINE 5			-10,506
SUB-TORAL (A):				-711,797
RELATED PARTIES	VII. LINE 14			-98,991

TOTAL ADJUSTMENTS (A) AND (B)		-810,788
V. ADJUSTMENT DETAIL/UTILITIES CARE RELATED AREAS;	PAGE 5	SQUARE FOOTAGE
THERAPEUTIC CENTER		22,122
JOSEPH,S		9,464
OLD NURSES STATION TO KITCHEN PASSAGEWAY		6,770
PASSAGEWAY		6,947
ADMINISTRATIVE BUILDING		6,890
ST. ALIYIOUS		9,270
NOVITIATE & AUDITORIUM		11,120
GUANELLA		15,887
ANGEL GUARDIAN		9,582
KITCHEN		5,749
BOILER & LAUNDRY		4,690
GARAGE		660
CHAPEL		12,468
CHAPLAIN.S HOUSE		4,022
GARAGE		1,012
ADMON BUILDING 2nd FLOOR		3,445
ST. MARY,S		11,691
ST. CLAIR.S		19,014
	TOTAL..	160,803
NON-CARE RELATED AREAS:		
NOVITIATE & AUDITORIUM		5,560
FARM HOUSE		1,768
	TOTAL	7,328
TOTAL SQUARE FOOTAGE		168,131
NON-CARE AREAS	7,328/168,131	.04
TOTAL UTILITIES LINE 5 PAGE 3		262,657
		X.04 =
TOTAL NON-CARE RELATED UTILITIES		10,506
XVII. INCOME STATEMENT OTHER REVENUE	PAGE 19	

DEVELOPMENTAL DAY TRAINING	LINE 28a	689,314
XVIII. A. STAFFING & SALARY COSTS	PAGE 20	
DEVELOPMENTAL DAY TRAINING	LINE 33	203,491
XX. GENERAL INFORMATION	PAGE 23	
COST ASSOCIATED WITH SPACE RENTAL LINE (14) NUNS QUARTERS		