



Facility Name & ID Number St Patricks Residence

# 0035006 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	206	Skilled (SNF)	206	75,190	1
2		Skilled Pediatric (SNF/PED)			2
3	3	Intermediate (ICF)	3	1,095	3
4		Intermediate/DD			4
5	1	Sheltered Care (SC)	1		5
6		ICF/DD 16 or Less			6
7	210	TOTALS	210	76,285	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	1,351	1,507	4,865	7,723	8
9	SNF/PED					9
10	ICF	29,652	31,703	32	61,387	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	31,003	33,210	4,897	69,110	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.59%

D. How many bed-hold days during this year were paid by the Department?

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES  NO

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

YES  NO

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

Date started 05/22/1989

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

YES  Date 05/22/1989 NO

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

YES  NO  If YES, enter number of beds certified 206 and days of care provided 4,627

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2013 Fiscal Year: 12/31/2013

\* 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 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	751,482	85,517		836,999		836,999		836,999		1
2	Food Purchase		463,415		463,415		463,415	(1,785)	461,630		2
3	Housekeeping			770,112	770,112		770,112		770,112		3
4	Laundry		899		899		899		899		4
5	Heat and Other Utilities			278,837	278,837		278,837	(12,751)	266,086		5
6	Maintenance	279,834	27,983	109,144	416,961		416,961		416,961		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	<b>1,031,316</b>	<b>577,814</b>	<b>1,158,093</b>	<b>2,767,223</b>		<b>2,767,223</b>	<b>(14,536)</b>	<b>2,752,687</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			24,200	24,200		24,200		24,200		9
10	Nursing and Medical Records	5,074,153	319,006	1,093,685	6,486,844		6,486,844		6,486,844		10
10a	Therapy	161,439	1,827	2,479	165,745		165,745		165,745		10a
11	Activities	255,889	11,937		267,826		267,826		267,826		11
12	Social Services	269,720	14,042		283,762		283,762	(150)	283,612		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>5,761,201</b>	<b>346,812</b>	<b>1,120,364</b>	<b>7,228,377</b>		<b>7,228,377</b>	<b>(150)</b>	<b>7,228,227</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	264,280		57,291	321,571		321,571		321,571		17
18	Directors Fees										18
19	Professional Services			138,790	138,790		138,790		138,790		19
20	Dues, Fees, Subscriptions & Promotions			44,736	44,736		44,736	(3,083)	41,653		20
21	Clerical & General Office Expenses	497,362	31,376	124,221	652,959		652,959	(156,092)	496,867		21
22	Employee Benefits & Payroll Taxes			1,679,173	1,679,173		1,679,173		1,679,173		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,065	2,065		2,065	(2,065)			24
25	Other Admin. Staff Transportation			16,109	16,109		16,109	(16,109)			25
26	Insurance-Prop.Liab.Malpractice			215,788	215,788		215,788		215,788		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	<b>761,642</b>	<b>31,376</b>	<b>2,278,173</b>	<b>3,071,191</b>		<b>3,071,191</b>	<b>(177,349)</b>	<b>2,893,842</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>7,554,159</b>	<b>956,002</b>	<b>4,556,630</b>	<b>13,066,791</b>		<b>13,066,791</b>	<b>(192,035)</b>	<b>12,874,756</b>		<b>29</b>

\*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 &amp; ID Number

St Patricks Residence

#0035006

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			557,655	557,655		557,655	157,549	715,204			30
31	Amortization of Pre-Op. & Org.			1,340	1,340		1,340		1,340			31
32	Interest			10,820	10,820		10,820	(10,820)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			569,815	569,815		569,815	146,729	716,544			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		228,270	497,154	725,424		725,424		725,424			39
40	Barber and Beauty Shops	44,266			44,266		44,266		44,266			40
41	Coffee and Gift Shops		52,370		52,370		52,370	(52,370)				41
42	Provider Participation Fee			506,158	506,158		506,158		506,158			42
43	Other (specify):*	116,201		110,121	226,322		226,322	(226,322)				43
44	<b>TOTAL Special Cost Centers</b>	160,467	280,640	1,113,433	1,554,540		1,554,540	(278,692)	1,275,848			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	7,714,626	1,236,642	6,239,878	15,191,146		15,191,146	(323,998)	14,867,148			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 Patricks Residence

# 0035006

Report Period Beginning:

01/01/2013

Ending:

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**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				3
4	Non-Patient Meals	(1,785)	2		4
5	Telephone, TV & Radio in Resident Rooms	(12,751)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	157,549	30		9
10	Interest and Other Investment Income	(10,820)	32		10
11	Discounts, Allowances, Rebates & Refunds	(8,721)	21		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				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	(50,175)	21		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	(397,295)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (323,998)		\$	30

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			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (323,998)		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY						
48		49		50		51
						52

St Patricks Residence

ID# 0035006

Report Period Beginning: 01/01/2013

Ending: 12/31/2013

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Coffee Shop Expense	\$ (51,470)	41	1
2	Phone Income	(18,037)	21	2
3	Stamp Income	(487)	21	3
4	Happy Hour Expense	(900)	41	4
5	Chapel Services	(150)	12	5
6	Investment Fees	(52,247)	21	6
7	Development Salaries	(116,201)	43	7
8	Development Expense	(50,585)	43	8
9	Golf Outing Expense	(36,365)	43	9
10	Fund Raising Expense	(23,171)	43	10
11	Non-Allowable Travel	(16,109)	25	11
12	Lobbying Expense	(3,083)	20	12
13	Continuing Education	(2,065)	24	13
14	Volunteer Coordinator	(26,425)	21	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	<b>Total</b>		(397,295)	49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number St Patricks Residence# 0035006

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

## 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	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,785)	0	0	0	0	0	0	0	0	0	0	(1,785)	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	(12,751)	0	0	0	0	0	0	0	0	0	0	(12,751)	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	<b>TOTAL General Services</b>	<b>(14,536)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(14,536)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
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	(150)	0	0	0	0	0	0	0	0	0	0	(150)	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	<b>TOTAL Health Care and Programs</b>	<b>(150)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(150)</b>	<b>16</b>
	<b>C. General Administration</b>													
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	(3,083)	0	0	0	0	0	0	0	0	0	0	(3,083)	20
21	Clerical & General Office Expenses	(156,092)	0	0	0	0	0	0	0	0	0	0	(156,092)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(2,065)	0	0	0	0	0	0	0	0	0	0	(2,065)	24
25	Other Admin. Staff Transportation	(16,109)	0	0	0	0	0	0	0	0	0	0	(16,109)	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	<b>TOTAL General Administration</b>	<b>(177,349)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(177,349)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(192,035)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(192,035)</b>	<b>29</b>



## STATE OF ILLINOIS

Facility Name & ID Number St Patricks Residence# 0035006

Report Period Beginning:

01/01/2013 Ending:

Summary B

12/31/2013

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
30	Depreciation	157,549	0	0	0	0	0	0	0	0	0	0	157,549	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(10,820)	0	0	0	0	0	0	0	0	0	0	(10,820)	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	<b>TOTAL Ownership</b>	<b>146,729</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>146,729</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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	(52,370)	0	0	0	0	0	0	0	0	0	0	(52,370)	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(226,322)	0	0	0	0	0	0	0	0	0	0	(226,322)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(278,692)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(278,692)</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(323,998)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(323,998)</b>	<b>45</b>

**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
See Page 6 - Supplemental		See Page 6 - Supplemental		See Page 6 - Supplemental		

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	22 Employee Benefits	\$ 306,382	Carmelite System for the Aged and Infirm, Inc.	100.00%	\$ 306,382	\$	1
2	V	26 Insurance	215,788	Carmelite System for the Aged and Infirm, Inc.	100.00%	215,788		2
3	V	24 Training	1,350	Carmelite System for the Aged and Infirm, Inc.	100.00%	1,350		3
4	V	22 Health/Dental	36,501	Carmelite System for the Aged and Infirm, Inc.	100.00%	36,501		4
5	V	22 Pension	4,263	Carmelite System for the Aged and Infirm, Inc.	100.00%	4,263		5
6	V	25 Travel	1,184	Carmelite System for the Aged and Infirm, Inc.	100.00%	1,184		6
7	V	17 Administrative	57,291	Carmelite System for the Aged and Infirm, Inc.	100.00%	57,291		7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	<b>Total</b>		\$ 622,759			\$ 622,759	\$ *	14

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

Facility Name & ID Number

St Patricks Residence

# 0035006

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

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	Carmelite Sisters for the Aged and	100%	None		Carmelite Sisters	Germantown, NY	Religious Order	1
2	Infirm, Inc.				for the Aged and Infirm, Inc.			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 Patricks Residence # 0035006 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

## VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

Facility Name & ID Number St Patricks Residence

# 0035006 Report Period Beginning: 01/01/2013

Ending: 2/31/2013

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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	<b>TOTALS</b>				\$	\$		\$	25

Facility Name &amp; ID Number

St Patricks Residence

# 0035006

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

## 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	Name of Lender	2		3	4	5	6		8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required				Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
	<b>A. Directly Facility Related</b>																
	<b>Long-Term</b>																
1	Great America Leasing Co.		X	Capital Lease	\$1,674.00	10/01/2009	\$ 72,700	\$ 14,628	10/01/2014		\$ 6,640	1					
2												2					
3												3					
4												4					
5												5					
	<b>Working Capital</b>																
6	Harris Bank		X	Working Capital		06/01/2013			06/01/2014	0.0325	4,180	6					
7												7					
8												8					
9	<b>TOTAL Facility Related</b>				\$1,674.00		\$ 72,700	\$ 14,628			\$ 10,820	9					
	<b>B. Non-Facility Related*</b>																
10	Interest Income		X								(10,820)	10					
11												11					
12												12					
13												13					
14	<b>TOTAL Non-Facility Related</b>						\$	\$			(10,820)	14					
15	<b>TOTALS (line 9+line14)</b>						\$ 72,700	\$ 14,628			\$	15					

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.)\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

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

**B. Real Estate Taxes**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>				
1. Real Estate Tax accrual used on 2012 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 2013 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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$			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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$			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:	2008	_____	8	<b>FOR BHF USE ONLY</b>		
	2009	_____	9			
	2010	_____	10			
	2011	_____	11			
	2012	_____	12			
				13	FROM R. E. TAX STATEMENT FOR 2012 \$	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.**

## 2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME St Patricks Residence COUNTY Dupage

FACILITY IDPH LICENSE NUMBER 0035006

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 2012 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 2012.

	(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.	_____	_____	\$ _____	\$ _____
		<b>TOTALS</b>	\$ _____	\$ _____

**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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

**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 Patricks Residence

# 0035006 Report Period Beginning:

01/01/2013 Ending:

12/31/2013

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 118,218 B. General Construction Type: Exterior CMV Block & Brick Frame Pre-Cast Concrete Number of Stories 3

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

None

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: 116,922 2. Number of Years Over Which it is Being Amortized: 15  
 3. Current Period Amortization: 1,340 4. Dates Incurred: 1997

Nature of Costs: \_\_\_\_\_  
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

**XI. OWNERSHIP COSTS:**

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>7.33 Acres</u>	<u>1987</u>	<u>\$ 638,590</u>	1
2					2
3	<b>TOTALS</b>	<u>7.33 Acres</u>		<u>\$ 638,590</u>	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	210		1989	1989	\$ 7,786,645	\$	25-40	\$ 275,257	\$ 275,257	\$ 6,784,885	4
5			1997	1997	2,194,676		40	54,867	54,867	905,305	5
6			2000	2000	2,987,034		40	74,675	74,675	977,514	6
7			2005	2005	894,078		35	26,422	26,422	233,141	7
8											8
	<b>Improvement Type**</b>										
9	Various		1991		4,862		20			4,862	9
10	Various		1993		6,175		20			6,175	10
11	Various		1994		32,324		20	75	75	32,290	11
12	Various		1996		2,976		20			2,976	12
13	Various		1997		52,566		20	2,030	2,030	45,461	13
14	Various		1998		28,215		20	514	514	18,658	14
15	Various		1999		6,832		20			6,832	15
16	Various		2000		16,581		20	829	829	11,192	16
17	Various		2001		10,440		20	522	522	6,525	17
18	Various		2002		3,966		20	196	196	3,966	18
19	Various		2005		10,938		20	1,094	1,094	9,298	19
20	Various		2006		226,358		20	18,282	18,282	136,484	20
21	Various		2007		101,740		20	5,177	5,177	33,651	21
22	Various		2008		250,909		20	14,612	14,612	80,367	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

\*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 &amp; ID Number St Patricks Residence

# 0035006

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

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

1		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	Boiler	2009	\$ 4,031	\$	20	\$ 202	\$ 202	\$ 907	37
38	Repair Coil On roof	2009	3,728		20	186	186	930	38
39	Front Entrance Sign	2009	5,288		20	176	176	880	39
40	Elevator Final Payment	2009	20,875		20	1,044	1,044	5,220	40
41	Repair 2 Roof Areas	2009	21,077		20	1,054	1,054	5,270	41
42	Firm Pump Repair	2009	3,402		20	170	170	850	42
43	Elevator Work	2009	2,500		20	63	63	315	43
44	Wander Prevention System	2009	6,963		20	348	348	1,740	44
45	SS Panels for Kitchen	2009	8,797		20	440	440	2,200	45
46	Replace Furnace New Addition	2009	6,134		20	307	307	1,535	46
47	42 Cornices	2009	6,005		20	300	300	1,500	47
48	Replace Txv Valve / Hallway AC	2009	2,835		20	142	142	710	48
49	Wander Prevention System	2009	8,484		20	424	424	2,120	49
50	Compressor	2009	4,117		20	206	206	1,030	50
51	Walk-In-Cooler	2009	19,874		20	662	662	3,310	51
52	Door Kick Plates	2009	6,060		20	303	303	1,515	52
53	Parts for Walk-In Cooler	2010	5,463		20	273	273	1,092	53
54	Walk-In Cooler	2010	7,951		20	398	398	1,591	54
55	Front Door Roam Alert System	2010	2,559		20	128	128	512	55
56	Air Curtain - Employee Entrance	2010	4,900		20	245	245	980	56
57	Booster Water Heater / Blaster Chiller	2010	10,496		20	525	525	2,100	57
58	Backflow Preventer	2010	13,139		20	657	657	2,628	58
59	Sprinkler Heads in Elevator	2010	4,630		20	232	232	927	59
60	Roofing Repairs	2010	8,500		20	425	425	1,700	60
61	A/C Pipes & Valves	2010	6,054		20	303	303	1,211	61
62	Walk-In Cooler	2010	17,593		20	880	880	3,519	62
63	Landscaping	2010	4,500		20	225	225	900	63
64	Roof Top Garden / Patio	2010	7,645		20	382	382	1,146	64
65	Air Curtain	2011	4,650		20	233	233	699	65
66	Security System - Employee Entrance	2011	8,245		20	412	412	1,236	66
67	Lobby A/C	2011	2,846		20	142	142	426	67
68	Lobby Compressor	2011	5,160		20	258	258	774	68
69									69
70	<b>TOTAL (lines 4 thru 69)</b>		\$ 14,861,816	\$		\$ 486,297	\$ 486,297	\$ 9,351,055	70

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

Facility Name &amp; ID Number St Patricks Residence

# 0035006

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

## 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	<b>Totals from Page 12A, Carried Forward</b>		\$ 14,861,816	\$		\$ 486,297	\$ 486,297	\$ 9,351,055	1
2	Privacy Curtains / Cornices	2011	11,956		20	598	598	1,794	2
3	Security System - Employee Entrance	2011	8,284		20	414	414	1,242	3
4	Roof Top Garden / Patio	2011	2,500		20	125	125	375	4
5	Roof Top Garden / Patio	2011	49,072		20	2,454	2,454	7,362	5
6	Roof Top Garden / Patio	2011	61,692		20	3,085	3,085	9,255	6
7	Back Door	2011	3,800		20	190	190	570	7
8	Concrete - Compactor Base Pad	2011	2,850		20	143	143	429	8
9	Roof Replacement	2011	19,700		20	985	985	2,955	9
10	Amex/Wet - Glycol for Heating System	2012	2,573		20	129	129	258	10
11	Amex/Chemicals for A/C System	2012	2,578		20	129	129	258	11
12	Wm F. Meyer - Sewer Rodder - Amex	2012	2,620		20	131	131	262	12
13	Chase/Classic Fence - Fence for Compactor	2012	2,768		20	138	138	276	13
14	Robert Gill & Co. - Shelving	2012	2,904		20	145	145	290	14
15	Amex/Sun Ray Heating - Repair Boiler Coil	2012	2,950		20	148	148	296	15
16	Amex/Break Room Flooring	2012	3,507		20	175	175	350	16
17	RJKeck Piping/Install PVC	2012	4,609		20	230	230	460	17
18	Metro Tank and Pump Co/Instl 300 Gal Tank	2012	5,000		20	250	250	500	18
19	Accelerated Care Plus Corp - Omnicycle Rehab System	2012	6,096		20	305	305	610	19
20	Chase/Replace HVAC Unit	2012	6,305		20	315	315	630	20
21	Metro Tank - Diesel Fuel Tank	2012	10,869		20	543	543	1,086	21
22	Precision Cntrl/Chase - Piping & Valve System	2012	11,355		20	568	568	1,136	22
23	Amex/Neuco - HVAC Air Handler	2012	14,323		20	716	716	1,432	23
24	Chase/Great Lakes Paving - Blacktop Front & Convent	2012	18,765		20	938	938	1,876	24
25	Great Lakes Paving - Resurface Front Lot/Circle	2012	21,600		20	1,080	1,080	2,160	25
26	Showalter Roofing Service Inc - Roof Repairs	2012	22,710		20	1,136	1,136	2,272	26
27	Great Lakes Paving - Paving	2013	14,175		20	945	945	945	27
28	Amex/Showalter Roofing - Roof Repair	2013	3,720		20	248	248	248	28
29	Chase/Showalter Roofing - Partial Roof Replacement	2013	2,560		20	171	171	171	29
30	Jim Wagner Plumbing - 2 Copper Hot Water Supply	2013	3,394		20	198	198	198	30
31	Amex/West Side Mech - Fire Dampers	2013	4,200		20	210	210	210	31
32	Gilkerson Masonry - Tuckpoint Block Walls	2013	12,760		20	532	532	532	32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 15,204,011	\$		\$ 503,671	\$ 503,671	\$ 9,391,493	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	<b>Totals from Page 12B, Carried Forward</b>		\$ 15,204,011	\$		\$ 503,671	\$ 503,671	\$ 9,391,493	1
2	Lowery Tiel	2013	5,092		20	42	42	42	2
3	Chase/Thermo Heat Exchanger Cleaning system	2013	3,422		5	399	399	399	3
4	Clost Designs & More - Coffee Shop Cabinets	2013	2,600		15	101	101	101	4
5	Edot - Install Surveillance Cameras	2013	3,000		10	175	175	175	5
6	Edot - Parking Lot Cameras	2013	3,120		10	156	156	156	6
7	Amex/Century Tile - Coffee Shop Tile - Guild	2013	3,023		20	63	63	63	7
8	Roseland Draperies - 2E/2W Cornices/Shades	2013	7,377		20	123	123	123	8
9	Amex/H-Mac Gas Duct Furnace	2013	3,188		15	18	18	18	9
10	Amex/West USA Ethylene Glycol 4-55 gal	2013	2,889		20	12	12	12	10
11	Entegra Procurement Svcs - Air Curtain Refrigerator	2013	10,976		15	61	61	61	11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
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22									22
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 15,248,698	\$		\$ 504,821	\$ 504,821	\$ 9,392,643	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	<b>Totals from Page 12H, Carried Forward</b>		\$ 15,248,698	\$		\$ 504,821	\$ 504,821	\$ 9,392,643	1
2	<b>Financial Statement Depreciation</b>			557,655			(557,655)		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
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 15,248,698	\$ 557,655		\$ 504,821	\$ (52,834)	\$ 9,392,643	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	\$ 3,849,423	\$	\$ 193,188	\$ 193,188	10	\$ 3,302,481	71
72	Current Year Purchases	75,938		7,594	7,594	10	7,594	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 3,925,361	\$	\$ 200,782	\$ 200,782		\$ 3,310,075	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		2001 Dodge Grand Caravan	2004	\$ 12,026	\$	\$	\$	5	\$ 12,026	76
77		2008 Chevy Bus	2007	49,512		4,951	4,951	5	30,532	77
78		2008 Silverado Pickup	2008	23,591		2,359	2,359	5	12,975	78
79		See Attached		14,913		2,291	2,291	5	8,602	79
80	TOTALS			\$ 100,042	\$	\$ 9,601	\$ 9,601		\$ 64,135	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)	\$ 19,912,691	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 557,655	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 715,204	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 157,549	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 12,766,853	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

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

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

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



Facility Name & ID Number St Patricks Residence

# 0035006

Report Period Beginning: 01/01/2013

Ending: 12/31/2013

**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	<b>TOTAL</b>				\$			7

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. \_\_\_\_\_ /2014 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2015 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2016 \$ \_\_\_\_\_

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

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

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

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

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

16. Rental Amount for movable equipment: \$ \_\_\_\_\_ Description: \_\_\_\_\_

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$	\$	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 Patricks Residence # 0035006 Report Period Beginning: 01/01/2013 Ending: 12/31/2013  
**XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)**

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

<p><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></p> <p><input type="checkbox"/> YES      <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p><b>2. CLASSROOM PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p><b>3. CLINICAL PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility			Total
		1	2	3	
		Drop-outs	Completed	Contract	
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	<b>TOTALS</b>	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	1 Schedule V Line & Column Reference	2 Staff		3 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$ 190,745	\$		\$ 190,745	1
2	Licensed Speech and Language Development Therapist		hrs			60,823			60,823	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			245,587			245,587	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescripts				197,588		197,588	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>See Supplemental</u>						30,682		30,682	12
13	Other (specify):									13
14	TOTAL			\$		\$ 497,155	\$ 228,270		\$ 725,425	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 &amp; ID Number St Patricks Residence

# 0035006

Report Period Beginning: 01/01/2013

Ending:

12/31/2013

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2013

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 863,191	\$	1
2	Cash-Patient Deposits	18,713		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	1,833,899		3
4	Supply Inventory (priced at )	52,284		4
5	Short-Term Investments			5
6	Prepaid Insurance	2,125		6
7	Other Prepaid Expenses	2,827		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 2,773,039	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	638,590		13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	15,076,847		15
16	Equipment, at Historical Cost	4,424,037		16
17	Accumulated Depreciation (book methods)	(12,074,581)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Grouped trial balance</u>	7,065,406		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 15,130,299	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 17,903,338	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 564,903	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	18,713		28
29	Short-Term Notes Payable	16,095		29
30	Accrued Salaries Payable	586,406		30
31	Accrued Taxes Payable (excluding real estate taxes)	20,239		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
	<b>Other Current Liabilities(specify):</b>			
36	<u>See Grouped Trial Balance</u>	309,036		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,515,392	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	1,309		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 1,309	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,516,701	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 16,386,637	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 17,903,338	\$	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 15,359,563	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 15,359,563	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	1,027,065	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) <b>Rounding</b>	9	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 1,027,074	17
<b>B. Transfers (Itemize):</b>			
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)	\$ 16,386,637	24 *

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

Facility Name & ID Number St Patricks Residence# 0035006Report Period Beginning: 01/01/2013Ending: 12/31/2013

**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	
I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 16,655,206	1
2	Discounts and Allowances for all Levels	(3,684,897)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 12,970,309</b>	<b>3</b>
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,242,202	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 1,242,202</b>	<b>8</b>
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants	5,000	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	53,388	12
13	Barber and Beauty Care	55,594	13
14	Non-Patient Meals	1,785	14
15	Telephone, Television and Radio	33,789	15
16	Rental of Facility Space	59,345	16
17	Sale of Drugs	192,336	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	25,111	19
20	Radiology and X-Ray	10,727	20
21	Other Medical Services	236,994	21
22	Laundry	38,336	22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 712,405</b>	<b>23</b>
<b>D. Non-Operating Revenue</b>			
24	Contributions	572,171	24
25	Interest and Other Investment Income***	703,451	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 1,275,622</b>	<b>26</b>
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	See Grouped Trial Balance	17,673	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 17,673</b>	<b>29</b>
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 16,218,211</b>	<b>30</b>

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	2,767,223	31
32	Health Care	7,228,377	32
33	General Administration	3,071,191	33
<b>B. Capital Expense</b>			
34	Ownership	569,815	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	1,048,382	35
36	Provider Participation Fee	506,158	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 15,191,146</b>	<b>40</b>
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>1,027,065</b>	<b>41</b>
42	<b>Income Taxes</b>		<b>42</b>
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ 1,027,065</b>	<b>43</b>

<b>III. Net Inpatient Revenue detailed by Payer Source</b>			
44	Medicaid - Net Inpatient Revenue	\$ 3,808,047	44
45	Private Pay - Net Inpatient Revenue	8,206,938	45
46	Medicare - Net Inpatient Revenue	955,324	46
47	Other-(specify)		47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	<b>\$ 12,970,309</b>	<b>49</b>

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? **Not Complete** 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 Patricks Residence**

# **0035006**

Report Period Beginning:

**01/01/2013**

Ending:

**12/31/2013**

**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	4,378	4,865	\$ 162,807	\$ 33.46	1
2	Assistant Director of Nursing					2
3	Registered Nurses	34,227	36,585	1,175,836	32.14	3
4	Licensed Practical Nurses	29,503	32,729	889,093	27.17	4
5	CNAs & Orderlies	161,722	179,691	2,846,417	15.84	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	10,060	11,202	161,439	14.41	8
9	Activity Director	2,131	2,283	34,756	15.22	9
10	Activity Assistants	21,118	22,169	221,133	9.97	10
11	Social Service Workers	12,834	14,066	269,720	19.18	11
12	Dietician	1,975	2,151	55,462	25.78	12
13	Food Service Supervisor	5,920	6,376	62,562	9.81	13
14	Head Cook					14
15	Cook Helpers/Assistants	49,027	53,216	633,457	11.90	15
16	Dishwashers					16
17	Maintenance Workers	15,125	16,935	279,834	16.52	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,080	2,280	95,256	41.78	20
21	Assistant Administrator	1,786	2,070	76,582	37.00	21
22	Other Administrative	2,018	2,322	92,442	39.81	22
23	Office Manager					23
24	Clerical	18,807	20,629	497,362	24.11	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)	7,110	7,714	160,467	20.80	33
34	TOTAL (lines 1 - 33)	379,821	417,283	\$ 7,714,625 *	\$ 18.49	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			35	
36	Medical Director	240	24,200	9-3	36
37	Medical Records Consultant	20	1,185	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	416	13,031	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	32	2,080	10A-3	44
45	Social Service Consultant				45
46	Other(specify) <u>Nurse Practitioner</u>	1,032	22,550	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,740	\$ 63,046		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	397	\$ 15,872	10-3	50
51	Licensed Practical Nurses	11,524	419,861	10-3	51
52	Certified Nurse Assistants/Aides	33,174	62,186	10-3	52
53	TOTAL (lines 50 - 52)	45,095	\$ 497,919		53





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	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	None	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name &amp; ID Number St Patricks Residence

# 0035006

Report Period Beginning: 01/01/2013

Ending: 12/31/2013

## 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. LSN - \$8,563
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (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? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 102,011 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. \_\_\_\_\_
- (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. \$ 506,158  
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? No 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. \$ \_\_\_\_\_ Has any meal income been offset against related costs? Yes Indicate the amount. \$ 1,785
- (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. \$ \_\_\_\_\_
- c. What percent of all travel expense relates to transportation of nurses and patients? None
- 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? 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? Yes  
Firm Name: CliftonLarsonAllen, LLP
- (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? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.