		FOR BHF USE			

LL1

2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

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: 0020495

Facility Name: Brother James Court

Address: 2508 St James Road (Number) Springfield (City) 62707 (Zip Code)

County: Sangamon

Telephone Number: 217-544-4676 Fax # 217-474-5914

HFS ID Number:

Date of Initial License for Current Owners: October 1, 1975

Type of Ownership:

X	VOLUNTARY,NON-PROFIT
X	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: Glenda Beatty Telephone Number: 217-747-5900
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 7/1/14 to 6/30/15 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed)	(Date)
	(Type or Print Name)	Glenda Beatty
	(Title)	Administrator
Paid Preparer	(Signed)	(Date)
	(Print Name and Title)	Richard Lynch Partner
	(Firm Name & Address)	Sikich LLP 3201 West White Oaks Drive
	(Telephone)	217-793-3363 Fax # 217-862-3529

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 Brother James Court # 0020495 Report Period Beginning: 7/1/14 Ending: 6/30/15

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	99	Intermediate/DD	99	36,135	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	99	TOTALS	99	36,135	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	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	28,147	365		28,512	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	28,147	365		28,512	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.90%

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)
____

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

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

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

I. On what date did you start providing long term care at this location?
Date started 10/1/1975

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

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

Medicare Intermediary ____

IV. ACCOUNTING BASIS

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

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

Tax Year: 6/30 Fiscal Year: 6/30

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

Facility Name & ID Number Brother James Court # 0020495 Report Period Beginning: 7/1/14 Ending: 6/30/15

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	200,037	19,693	8,167	227,897		227,897		227,897			1
2	Food Purchase		203,495		203,495		203,495		203,495			2
3	Housekeeping	61,942	22,346		84,288		84,288		84,288			3
4	Laundry	54,476	8,540		63,016		63,016		63,016			4
5	Heat and Other Utilities			176,649	176,649		176,649		176,649			5
6	Maintenance	71,020	434	76,177	147,631		147,631		147,631			6
7	Other (specify):*											7
8	TOTAL General Services	387,475	254,508	260,993	902,976		902,976		902,976			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,449,966	50,585	18,282	1,518,833		1,518,833		1,518,833			10
10a	Therapy	16,556		15,880	32,436		32,436		32,436			10a
11	Activities	28,812			28,812		28,812		28,812			11
12	Social Services	97,693	575	3,300	101,568		101,568		101,568			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,593,027	51,160	37,462	1,681,649		1,681,649		1,681,649			16
	C. General Administration											
17	Administrative	80,855		36,811	117,666		117,666	(117,666)				17
18	Directors Fees											18
19	Professional Services			275,327	275,327		275,327		275,327			19
20	Dues, Fees, Subscriptions & Promotions			10,693	10,693		10,693		10,693			20
21	Clerical & General Office Expenses	181,755	18,795	146,540	347,090		347,090		347,090			21
22	Employee Benefits & Payroll Taxes			450,068	450,068		450,068		450,068			22
23	Inservice Training & Education											23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			78,147	78,147		78,147		78,147			26
27	Other (specify):*											27
28	TOTAL General Administration	262,610	18,795	997,586	1,278,991		1,278,991	(117,666)	1,161,325			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,243,112	324,463	1,296,041	3,863,616		3,863,616	(117,666)	3,745,950			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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			168,632	168,632		168,632	104,131	272,763			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			102	102		102		102			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			310,500	310,500		310,500	(310,500)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			479,234	479,234		479,234	(206,369)	272,865			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			243,412	243,412		243,412		243,412			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			243,412	243,412		243,412		243,412			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,243,112	324,463	2,018,687	4,586,262		4,586,262	(324,035)	4,262,227			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 Brother James Court # 0020495 Report Period Beginning: 7/1/14 Ending: 6/30/15

VI. ADJUSTMENT DETAIL A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				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				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	(36,811)	17		24
25	Fund Raising, Advertising and Promotional	(80,855)	17		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (117,666)		$	30

BHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(206,369)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (206,369)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (324,035)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Brother James Court

ID# 0020495

Report Period Beginning: 7/1/14

Ending: 6/30/15

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
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				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Brother James Court # 0020495 Report Period Beginning: 7/1/14 Ending: 6/30/15

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

	Operating Expenses A. General Services	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)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	(117,666)	0	0	0	0	0	0	0	0	0	0	(117,666)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(117,666)	0	0	0	0	0	0	0	0	0	0	(117,666)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(117,666)	0	0	0	0	0	0	0	0	0	0	(117,666)	29

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	0	104,131	0	0	0	0	0	0	0	0	0	104,131	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(310,500)	0	0	0	0	0	0	0	0	0	(310,500)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	(206,369)	0	0	0	0	0	0	0	0	0	(206,369)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(117,666)	(206,369)	0	0	0	0	0	0	0	0	0	(324,035)	45

Facility Name & ID Number Brother James Court # 0020495 Report Period Beginning: 7/1/14 Ending: 6/30/15

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
N/A	N/A	N/A	N/A	Franciscan Brothers o	Springfield	Religious Order
				Springfield Developme	Springfield	Day training progra
				Weber Care Corporati	Springfield	Community living fa

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Facility Rent	$ 310,500	Franciscan Brothers of the Holy Cross	100.00%	$	$ (310,500)	1
2	V	30	Depreciation		Franciscan Brothers of the Holy Cross	100.00%	104,131	104,131	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			$ 310,500			$ 104,131	$ * (206,369)	14

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

Facility Name & ID Number Brother James Court # 0020495 Report Period Beginning: 7/1/14 Ending: 6/30/15

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								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: Brother James Court # 0020495 Report Period Beginning: 7/1/14 Ending: 6/30/15

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
					Compensation Received From Other	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column	
	Name	Title	Function	Ownership Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
1	Brother Anthony Joseph McC	Mission Effectiveness		None	None	40		Consultant	$ 17,520	21, I	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	$ 17,520		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 Brother James Court # 0020495 Report Period Beginning: 7/1/14 Ending: 6/30/15

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 [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

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

Facility Name & ID Number Brother James Court # 0020495 Report Period Beginning: 7/1/14 Ending: 6/30/15

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							$	$			$	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.)**

Facility Name & ID Number Brother James Court # 0020495 Report Period Beginning: 7/1/14 Ending: 6/30/15

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.

Description	Amount	Line
1. Real Estate Tax accrual used on 2014 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 2015 report. (Detail and explain your calculation of this accrual on the lines below.)	$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			Line
	2010		8
	2011		9
	2012		10
	2013		11
	2014		12

Line	FOR BHF USE ONLY		Line
13	FROM R. E. TAX STATEMENT FOR 2014	$	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.

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Brother James Court COUNTY Sangamon

FACILITY IDPH LICENSE NUMBER 0020495

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 2014 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 2014.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
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 __________ 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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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: 47,210 B. General Construction Type: Exterior Brick/stone Frame Steel Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

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

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

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A 2. Number of Years Over Which it is Being Amortized: N/A

3. Current Period Amortization: N/A 4. Dates Incurred: N/A

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number Brother James Court # 0020495 Report Period Beginning: 7/1/14 Ending: 6/30/15

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1975	1975	$ 1,003,250	$	30	$	$	$ 1,003,250	4
5			1996	1996	1,251,493		30	41,716	41,716	771,753	5
6			1997	1997	1,256,490		30	41,883	41,883	716,660	6
7											7
8											8
	Improvement Type**										
9	Repave Parking Lot			1986	42,236		10			42,236	9
10	BJC - Bldg Improvement			1980	16,233		11			16,233	10
11	BJC - Bldg Improvement			1984	21,419		10			21,419	11
12	BJC - Bldg Improvement			1987	69,555		10			69,555	12
13	Insulation			1991	9,175		15			9,175	13
14	BJC - Steam Line			1985	14,479		10			14,479	14
15							15				15
16	BJC - Bldg Improvement			1975	19,600		24			19,600	16
17	BJC - Sidewalk/ Patio			1976	3,545		10			3,545	17
18	BJC - Bike Rink			1978	2,500		5			2,500	18
19	BJC - Site Improvement			1979	1,440		26			1,440	19
20	BJC - Roof			1979	12,166		10			21,166	20
21	Remodeling			1988	46,656		10			46,656	21
22	BJC - Water Line			1989	3,166		20			3,166	22
23	Sewage Treatment Plant			1990	6,411		20			6,411	23
24	Tank Removal			1991	9,809		10			9,809	24
25	Parking Lot			1992	10,453		10			10,453	25
26	Repaving Parking Lot			1994	850		10			850	26
27	Pump			1994	734		10			734	27
28	BJC - Site Improvement			1996	3,470		20	174	174	3,181	28
29	Gate			1999	550		5			550	29
30	Remodeling			1999	5,773		10			5,773	30
31	Floor			2000	1,683		7			1,683	31
32	Roof			2011	6,493		10	649	649	2,002	32
33	Patio			2011	7,385		10	739	739	2,523	33
34	Fire Alarm			2011	1,551		10	155	155	465	34
35	Plastering			2011	31,508		10	3,151	3,151	9,452	35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Brother James Court # 0020495 Report Period Beginning: 7/1/14 Ending: 6/30/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Pavement	2011	$ 6,800	$	10	$ 680	$ 680	$ 2,323	37
38	Landscaping	2011	7,157		10	716	716	2,505	38
39	Fence	2011	2,375		10	238	238	792	39
40	Entrance lighting	2011	11,150		10	1,115	1,115	4,181	40
41	Light Fixtures	2011	1,321		10	132	132	418	41
42	Bell Tower roof	2011	7,960		10	796	796	2,786	42
43	Water line	1998	14,120		20			14,120	43
44	Boiler Room	1993	15,106		20			15,106	44
45	Boiler Room	1994	170,330		20	5,467	5,467	170,330	45
46	Boiler Room	1992	12,498		20			12,498	46
47									47
48	Total Life Center	1998	122,261		30	4,075	4,075	67,583	48
49	BJC - Improvements	1998	15,712		30	524	524	8,816	49
50									50
51	New Wing	1997	18,883		30	629	629	11,068	51
52	Water line repair	1999	3,102		10			3,102	52
53	BJC -Site Improvements	1999	25,849		20	1,292	1,292	19,817	53
54	leasehold improvement	1985	15,200		10			15,200	54
55	leasehold improvement	1986	19,507		10			19,507	55
56	painting	1987	9,922		3			9,922	56
57	steel doors	1987	6,020		10			6,020	57
58	window	1987	2,013		10			2,013	58
59	emergency generator switch	1988	3,335		10			3,335	59
60	remodel lobby	1989	156,996	5,233	30	5,233		133,883	60
61	bus hut	1989	4,715		15			4,715	61
62	hot water heater	1989	6,721		10			6,721	62
63	transfer switch	1989	1,127		10			1,127	63
64	energy panel	1989	8,633		10			8,633	64
65	roof repair	1990	6,928		10			6,928	65
66	remodeling	1990	6,953		30			5,833	66
67	overhead door	1990	1,220	232	10	232		1,220	67
68	kitchen tanks	1990	3,089		10			3,089	68
69	plaster	1990	1,649		10			1,649	69
70	TOTAL (lines 4 thru 69)		$ 4,548,726	$ 5,465		$ 109,596	$ 104,131	$ 3,381,959	70

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

Facility Name & ID Number Brother James Court # 0020495 Report Period Beginning: 7/1/14 Ending: 6/30/15

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 12A, Carried Forward		$ 4,548,726	$ 5,465		$ 109,596	$ 104,131	$ 3,381,959	1
2	plastering	1990	937		10			937	2
3	ceiling	19990	2,970		10			2,970	3
4	office signs	1990	170		10			170	4
5	roof repair	1990	2,200		10			2,200	5
6	leasehold improvemenr	1990	8,762		10			8,762	6
7	leasehold improvemenr	1990	11,633		10			11,633	7
8	leasehold improvemenr	1990	3,250		10			3,250	8
9	chair fabric	1991	25		5			25	9
10	gym seat	1991	44		5			44	10
11	drapes	1991	289		5			289	11
12	drapes	1991	908		5			908	12
13	tile installation	1991	876		10			876	13
14	window	1992	2,750		10			2,750	14
15	cafeteria door	1993	11,918		10			11,918	15
16	plumbing work	1994	6,858		10			6,858	16
17	wall and door repair	1995	2,596		10			2,596	17
18	door	1996	656		10			656	18
19	painting	1996	1,620		3			1,620	19
20	furnace	1996	502		10			502	20
21	grip caps	1996	1,575		5			1,575	21
22	bedding	1996	1,505		3			1,505	22
23	air deflectors	1996	381		3			381	23
24	shower	1996	259		5			259	24
25	remodeling	1996	4,928		10			4,928	25
26	roof repair	1997	798		10			798	26
27	drapes	1997	4,500		5			4,500	27
28	floor	1997	1,722		10			1,722	28
29	drapes	1997	3,153		5			3,153	29
30	floor	1997	4,422		10			4,422	30
31	painting	1997	8,917		10			8,917	31
32	redecorate snack lounge	1999	2,847		5			2,847	32
33	roof repair	1999	846		10			846	33
34	TOTAL (lines 1 thru 33)		$ 4,643,543	$ 5,465		$ 109,596	$ 104,131	$ 3,476,776	34

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

Facility Name & ID Number Brother James Court # 0020495 Report Period Beginning: 7/1/14 Ending: 6/30/15

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		$ 4,643,543	$ 5,465		$ 109,596	$ 104,131	$ 3,476,776	1
2	carpet	1999	8,881		5			8,881	2
3	yard sign	1999	2,825		10			2,825	3
4	vinyl wall covering	1999	1,127		10			1,127	4
5	shower room	1999	8,220		10			8,220	5
6	sewer connection	1998	7,438		10			7,438	6
7	tree removal	1999	9,857		10			9,857	7
8	condenser	1999	12,396		10			12,396	8
9	drop rod assembly	1999	6,408		10			6,408	9
10	fencing	1999	3,840		10			3,840	10
11	trees	1999	9,905		10			9,905	11
12	roof repair	2000	2,300		10			2,300	12
13	tile floor	2000	34,740		10			34,740	13
14	glass for windows	2000	2,009		10			2,009	14
15	cabinet	1999	4,520		7			4,520	15
16	electrical	1999	17,410		15			17,410	16
17	sign	1999	900		5			900	17
18	masonry	1999	23,465		15			23,465	18
19	plumbing/heating	1999	31,000		15			31,000	19
20	redmodeling	1999	19,524		15			19,524	20
21	parking lot stripes	2000	1,549		5			1,549	21
22	painting	2000	664		5			664	22
23	ramp	2001	14,387		5			14,387	23
24	painting	2001	8,058		5			8,058	24
25	air curtain	2001	1,812		7			1,812	25
26	receptacles	2001	9,820		5			9,820	26
27	shower room floor	2002	1,123		10			1,123	27
28	boiler	2002	3,960		5			3,960	28
29	drapes	2002	4,200		5			4,200	29
30	architect bathroom	2002	9,863		3			9,863	30
31	sidewalks	2002	810		10			810	31
32	tuckpointing	2002	1,490		10			1,490	32
33	floors for wing	2002	2,688		10			2,688	33
34	TOTAL (lines 1 thru 33)		$ 4,910,732	$ 5,465		$ 109,596	$ 104,131	$ 3,743,965	34

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

Facility Name & ID Number Brother James Court # 0020495 Report Period Beginning: 7/1/14 Ending: 6/30/15

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 12C, Carried Forward		$ 4,910,732	$ 5,465		$ 109,596	$ 104,131	$ 3,743,965	1
2	keypad lock	2002	580		10			580	2
3	hot water storage tank	2002	4,409		10			4,409	3
4	doors and frames	2003	3,733		10			3,733	4
5	pole lighting	2003	3,740	249	15	249		2,888	5
6	sink faucet	2004	1,133		7			1,133	6
7	wallpaper	2004	2,358	157	15	157		1,729	7
8	doors	2004	4,987	332	15	332		3,713	8
9	ceiling fan	2004	1,082		7			1,082	9
10	electric work	2004	16,000	1,067	15	1,067		11,733	10
11	alarm	2004	2,204		7			2,204	11
12	parking lot	2004	3,443	344	10	344		3,443	12
13	boiler	2004	4,871		7			4,871	13
14	boiler	2004	6,900		7			6,900	14
15	boiler	2004	7,200		7			7,200	15
16	hvac	2004	12,497		7			12,497	16
17	parking lot	2004	74,847	2,495	30	2,495		27,236	17
18	dentist office renovation	2004	57,955	1,932	30	1,932		20,767	18
19	pole light replacement	2004	1,868		7			1,868	19
20	storage room	2004	2,375		7			2,375	20
21	bathroom repair	2005	4,232		5			4,232	21
22	alarm	2005	3,000	300	10	300		2,925	22
23	alarm	2005	3,041	304	10	304		2,914	23
24	roof	2006	22,370	1,119	20	1,119		10,719	24
25	water heater	2006	32,250	3,225	10	3,225		30,369	25
26	boiler	2006	4,611		7			4,611	26
27	bathroom repair	2006	6,959		7			6,959	27
28	generator	2007	2,814		5			2,814	28
29	alarm	2007	3,325	333	10	333		2,688	29
30	new roof	2007	90,882	3,029	30	3,029		23,983	30
31	flood light	2008	945	95	10	95		740	31
32	water heater	2008	71,300	7,130	10	7,130		46,345	32
33	a/c unit	2009	7,934	793	10	793		5,091	33
34	TOTAL (lines 1 thru 33)		$ 5,376,577	$ 28,369		$ 132,500	$ 104,131	$ 4,008,716	34

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

Facility Name & ID Number Brother James Court # 0020495 Report Period Beginning: 7/1/14 Ending: 6/30/15

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 12D, Carried Forward		$ 5,376,577	$ 28,369		$ 132,500	$ 104,131	$ 4,008,716	1
2	alarm upgrade	2009	1,240	124	10	124		775	2
3	power supply for ac	2009	1,443		3			1,443	3
4	hot water system	2008	5,600	800	7	800		5,400	4
5	a/c rooftop unit	2009	27,544	2,754	10	2,754		16,526	5
6	bath room	2009	3,346	478	7	478		2,868	6
7	seal parking	2009	3,315	474	7	474		2,841	7
8	repaving track	2009	8,400	1,200	7	1,200		7,400	8
9	bathroom	2009	44,169	6,310	7	6,310		37,333	9
10	repave walking path	2009	1,450	207	7	207		1,208	10
11	brick on garage	2009	12,330	1,233	10	1,233		7,090	11
12	water piping	2009	12,968	1,853	7	1,853		10,498	12
13	sewer station	2009	15,375	2,196	7	2,196		12,263	13
14	extend mains to new pipes	2009	2,787	398	7	398		2,223	14
15	boiler room roof	2010	15,462	515	30	515		2,706	15
16	office furniture	2010	14,885	2,233	5	2,233		14,885	16
17	light fixture	2010	4,791	798	5	798		4,791	17
18	water heater	2011	16,761	1,676	10	1,676		6,844	18
19	roof repair	2011	6,804	680	10	680		2,722	19
20	sewer grinder	2010	23,908	2,391	10	2,391		11,356	20
21	roof repair	2010	19,800	990	20	990		4,785	21
22	bathroom tile	2010	1,200	120	10	120		540	22
23	cabinets	2011	1,867	373	5	373		1,649	23
24	sidewalk	2010	4,169	417	10	417		1,980	24
25	drain	2010	3,611	361	10	361		1,806	25
26	outdoor lighting	2010	4,184	837	5	837		4,114	26
27	door	2010	4,169	417	10	417		2,050	27
28	front sidewalk	2010	8,850	885	10	885		4,278	28
29	front door	2010	11,541	1,154	10	1,154		5,578	29
30	electric	2010	2,119	212	10	212		1,007	30
31	seal coat parking	2011	3,500	233	15	233		914	31
32	garage door	2011	6,577	329	20	329		1,288	32
33	concrete	2011	4,465	298	15	298		1,141	33
34	TOTAL (lines 1 thru 33)		$ 5,675,207	$ 61,315		$ 165,446	$ 104,131	$ 4,191,018	34

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

Facility Name & ID Number Brother James Court # 0020495 Report Period Beginning: 7/1/14 Ending: 6/30/15

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 12E, Carried Forward		$ 5,675,207	$ 61,315		$ 165,446	$ 104,131	$ 4,191,018	1
2	hose and cart	2011	113	11	10	11	(0)	43	2
3	sidewalk	2011	8,250	825	10	825		3,162	3
4	garage window	2011	6,875	688	10	688		2,578	4
5	kitchen cabinets	2011	3,980	398	10	398		1,459	5
6	countertops	2011	1,120	56	20	56		205	6
7	alarm video	2012	5,998	600	10	600		1,999	7
8	double door	2012	2,552	170	15	170		567	8
9	drapery	2012	2,564	256	10	256		833	9
10	curtain rod	2012	96	9	10	9		31	10
11	window	2012	15,208	1,521	10	1,521		4,562	11
12	cabinets	2011	2,786	186	15	186		666	12
13	curtain	2011	3,006	301	10	301		1,052	13
14	tile removal	2012	5,260	526	10	526		1,490	14
15	floor tile	2012	4,200	420	10	420		1,190	15
16	heat exchanger	2012	15,664	1,044	15	1,044		2,872	16
17	fire sprinkler	2012	44,209	8,842	5	8,842		24,315	17
18	fire alarm system	2013	40,199	8,040	5	8,040		19,430	18
19	fire alarm garage	2013	5,374	1,075	5	1,075		2,239	19
20	golf cart	2014	8,235	1,647	5	1,647		1,922	20
21	5 dell computers	2014	3,725	745	5	745		869	21
22	1 dell laptop	2014	1,001	200	5	200		234	22
23	5 dell 23" monitors	2014	975	195	5	195		228	23
24	4 dell 19" monitors	2014	660	132	5	132		143	24
25	tank sump pump	2013	4,396	440	10	440		843	25
26	horizantal boiler feed water	2013	15,670	2,239	7	2,239		3,731	26
27	printer	2014	296	59	5	59		64	27
28	printer	2014	296	59	5	59		64	28
29	fire alarm plant service	2013	9,133	1,827	5	1,827		2,740	29
30	smoke detector	1998	20,108		5			20,108	30
31	boiler	1996	3,335		10			3,335	31
32	door repair	2002	6,197		10			6,197	32
33	drapery	2001	10,881		5			10,881	33
34	TOTAL (lines 1 thru 33)		$ 5,927,569	$ 93,826		$ 197,957	$ 104,131	$ 4,311,070	34

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

Facility Name & ID Number Brother James Court # 0020495 Report Period Beginning: 7/1/14 Ending: 6/30/15

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 12F, Carried Forward		$ 5,927,569	$ 93,826		$ 197,957	$ 104,131	$ 4,311,070	1
2	floor	1997	2,658		7			2,658	2
3	land improvements	1996	1,385		3			1,385	3
4	landscaping	1999	18,255		10			18,255	4
5	leasehold improvements	2003	5,754		5			5,754	5
6	leasehold improvements	1999	2,598		5			2,598	6
7	leasehold improvements	1990	6,629		10			6,629	7
8	new valves	1999	11,685		10			11,685	8
9	painting	1995	3,076		10			3,076	9
10	painting	2000	6,352		5			6,352	10
11	parking lot security system	2005	20,404		7			20,404	11
12	repairs	1996	10,702		5			10,702	12
13	roof repairs	1996	5,985		10			5,985	13
14	sewer	1996	9,387		10			9,387	14
15	strip and refinish floors	2002	8,702		10			8,702	15
16	toilet room addition	2004	699,826	23,328	30	23,328		268,981	16
17	Parking lot light	2014	5,380	329	15	329		329	17
18	B&G Electric Pump	2014	644	39	15	39		39	18
19	Nurse Door Alarm	2015	13,343	297	15	297		297	19
20	Door Alarm	2015	11,764	196	15	196		196	20
21	Door Alarm	2015	17,867	198	15	198		198	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)		$ 6,789,965	$ 118,213		$ 222,344	$ 104,131	$ 4,694,682	34

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

Facility Name & ID Number Brother James Court # 0020495 Report Period Beginning: 7/1/14 Ending: 6/30/15

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	$ 269,444	$ 32,125	$ 32,125	$	various	$ 150,164	71
72	Current Year Purchases	36,988	2,536	2,536		various	2,536	72
73	Fully Depreciated Assets	1,736,302				various	176,302	73
74								74
75	TOTALS	$ 2,042,734	$ 34,661	$ 34,661	$		$ 329,002	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	Facility Use	Trucks	various	$ 9,500	$ 1,900	$ 1,900	$	5	$ 2,850	76
77	Resident Transportation	Vans	various	55,071	10,462	10,462		5	35,106	77
78	Resident Transportation	Auto - Fully Depreciated	various	138,521				5	138,521	78
79	Resident Transportation	Autos	various	18,486	3,389	3,389		5	18,486	79
80	TOTALS			$ 221,578	$ 15,751	$ 15,751	$		$ 194,963	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)	$ 9,054,277	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 168,625	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 272,756	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 104,131	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 5,218,647	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.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Franciscan Brothers of the Holy Cross
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 [X] 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 [X] NO Terms: *

10. Effective dates of current rental agreement:
Beginning 1975
Ending 2016

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

	Fiscal Year Ending	Annual Rent
12.	/2016	$ 310,500
13.	/2017	$ 310,500
14.	/2018	$ 310,500

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

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ None Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number Brother James Court # 0020495 Report Period Beginning: 7/1/14 Ending: 6/30/15

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? [X] 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	X
IN OTHER FACILITY	
COMMUNITY COLLEGE	
HOURS PER CNA	40

3. CLINICAL PORTION:

IN-HOUSE PROGRAM	X
IN OTHER FACILITY	
HOURS PER CNA	80

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies		447		447
3	Classroom Wages (a)		4,838		4,838
4	Clinical Wages (b)		8,416		8,416
5	In-House Trainer Wages (c)		3,678		3,678
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$ 17,379	$	$ 17,379
10	SUM OF line 9, col. 1 and 2 (e)	$ 17,379			

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

COMPLETED	
1. From this facility	11
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	11

(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		visits							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			$		$	$		$	14

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

Facility Name & ID Number Brother James Court # 0020495 Report Period Beginning: 7/1/14 Ending: 6/30/15

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 6/30/15 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 584,134	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	645,569		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	205,245		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	29,013		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,463,961	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	2,651,876		12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	2,483,557		15
16	Equipment, at Historical Cost	2,276,164		16
17	Accumulated Depreciation (book methods)	(3,630,289)		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)**	$ 3,781,308	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,245,269	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 399,220	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	66,002		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	Accrued Vacation	87,749		36
37	Accrued Pension	90,000		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 642,971	$	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)**	$ 642,971	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 4,602,298	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,245,269	$	48

*(See instructions.)

Facility Name & ID Number Brother James Court # 0020495 Report Period Beginning: 7/1/14 Ending: 6/30/15

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 5,356,313	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 5,356,313	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(754,015)	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)**	$ (754,015)	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)**	$ 4,602,298	24 *

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

Facility Name & ID Number Brother James Court # 0020495 Report Period Beginning: 7/1/14 Ending: 6/30/15

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,673,250	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,673,250	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	19,879	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	8,458	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 28,337	23
	D. Non-Operating Revenue		
24	Contributions	93,449	24
25	Interest and Other Investment Income***	23,884	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 117,333	26
	E. Other Revenue (specify):****		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	misc income	13,327	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 13,327	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,832,247	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	902,976	31
32	Health Care	1,681,649	32
33	General Administration	1,278,991	33
	B. Capital Expense		
34	Ownership	479,234	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	243,412	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,586,262	40
41	**Income before Income Taxes (line 30 minus line 40)****	(754,015)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (754,015)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,070,635	44
45	Private Pay - Net Inpatient Revenue	46,355	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) Social Security Benefits and SSI Benefits	556,260	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,673,250	49

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

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

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

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

Facility Name & ID Number Brother James Court # 0020495 Report Period Beginning: 7/1/14 Ending: 6/30/15

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	2,024	2,040	$ 56,990	$ 27.94	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses	18,433	19,452	363,384	18.68	4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,847	2,078	16,556	7.97	8
9	Activity Director	2,072	2,152	28,812	13.39	9
10	Activity Assistants					10
11	Social Service Workers	56	56	4,496	80.29	11
12	Dietician					12
13	Food Service Supervisor	2,040	2,293	28,885	12.60	13
14	Head Cook					14
15	Cook Helpers/Assistants	17,005	17,853	171,152	9.59	15
16	Dishwashers					16
17	Maintenance Workers	3,873	4,173	71,020	17.02	17
18	Housekeepers	5,275	5,682	61,942	10.90	18
19	Laundry	4,074	4,287	54,476	12.71	19
20	Administrator	1,704	1,784	80,855	45.32	20
21	Assistant Administrator					21
22	Other Administrative	10,904	11,580	181,755	15.70	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	4,943	5,083	93,197	18.34	28
29	Resident Services Coordinator	320	320	8,100	25.31	29
30	Habilitation Aides (DD Homes)	89,629	95,617	1,014,537	10.61	30
31	Medical Records			6,955		31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	164,199	174,450	$ 2,243,112 *	$ 12.86	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	various	$ 8,167	1, 3	35
36	Medical Director				36
37	Medical Records Consultant	various	17,372	10, 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	various	910	10, 3	39
40	Physical Therapy Consultant	various	664	10a, 3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	various	3,300	12, 3	45
46	Other(specify)				46
47	Psychologust Consultant	various	15,216	10a, 3	47
48					48
49	TOTAL (lines 35 - 48)		$ 45,629		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

Facility Name & ID Number: Brother James Court # 0020495 Report Period Beginning: 7/1/14 Ending: 6/30/15

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Cindy Russell & Glenda Beatty	Administrator	0	$ 80,855
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 80,855

B. Administrative - Other

Description	Amount
	$ 36,811
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 36,811

C. Professional Services

Vendor/Payee	Type	Amount
Sikich	Audit/Accounting	$ 95,921
INB/Marine Bank	Trust/Fudiciary Fees	9,142
Legal	Legal	169,765
Training	Payroll/timeclock	499
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 275,327

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 96,020
Unemployment Compensation Insurance	60,530
FICA Taxes	171,266
Employee Health Insurance	26,767
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Life Insurance	3,339
401K Contribution	79,757
Continuing Education	1,719
Staff Recognition	3,354
Employee Physical	7,316
TOTAL (agree to Schedule V, line 22, col.8)	$ 450,068

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	4,509
Health Care Worker Background Check	756
(Indicate # of checks performed)	
Patient Background Checks	
Dues and Subscription	2,928
IDPH Fines	2,500
Late Fees	
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 10,693

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Brother James Court # 0020495 Report Period Beginning: 7/1/14 Ending: 6/30/15

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
					Amount of Expense Amortized Per Year								
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number **Brother James Court** **#** **0020495** **Report Period Beginning:** **7/1/14** **Ending:** **6/30/15**

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? **No**
If YES, give association name and amount. **N/A**

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

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

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **0** Line ______

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **243,412**
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. $ **None** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **Yes**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **Yes** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **8,458**
c. What percent of all travel expense relates to transportation of nurses and patients? **100**
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? **No**
Firm Name: ______

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

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.