FOR BHF USE

LL1

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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

I. IDPH License ID Number: 0005520

Facility Name: Mount St Joseph

Address: 24955 North Hwy 12 (Number) Lake Zurich (City) 60047 (Zip Code)

County: Lake

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

HFS ID Number:

Date of Initial License for Current Owners: 1947

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

IRS Exemption Code 501(c)(3)

In the event there are further questions about this report, please contact:
Name: Michael P. Sullivan **Telephone Number:** 847-438-5050 EXT 116
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 7/1/2015 to 6/30/2016 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) October 25, 2016 (Date)
(Type or Print Name) Sister Janet Kosman
(Title) Administrator

Paid Preparer

(Signed) (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

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

Facility Name & ID Number Mount St Joseph # 0005520 Report Period Beginning: 7/1/2015 Ending: 6/30/2016

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	132	Intermediate/DD	129	47,085	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	132	TOTALS	129	47,085	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	37,326	725		38,051	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	37,326	725		38,051	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.81%

D. How many bed-hold days during this year were paid by the Department?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

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

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

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

I. On what date did you start providing long term care at this location?
Date started 1947

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

Tax Year: 6/30/2016 Fiscal Year: 6/30/2016

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

Facility Name & ID Number Mount St Joseph # 0005520 Report Period Beginning: 7/1/2015 Ending: 6/30/2016

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	184,032			184,032		184,032	(18,403)	165,629			1
2	Food Purchase		160,386		160,386		160,386	(16,039)	144,347			2
3	Housekeeping	338,017			338,017		338,017		338,017			3
4	Laundry	42,359	4,122		46,481		46,481		46,481			4
5	Heat and Other Utilities			225,786	225,786		225,786	(9,031)	216,755			5
6	Maintenance	214,326	28,793		243,119		243,119		243,119			6
7	Other (specify):*							(820,977)	(820,977)			7
8	TOTAL General Services	778,734	193,301	225,786	1,197,821		1,197,821	(864,450)	333,371			8
	B. Health Care and Programs											
9	Medical Director			36,000	36,000		36,000		36,000			9
10	Nursing and Medical Records	2,600,358	69,709	18,179	2,688,246	(27,792)	2,660,454		2,660,454			10
10a	Therapy	86,550			86,550		86,550		86,550			10a
11	Activities											11
12	Social Services			7,296	7,296		7,296		7,296			12
13	CNA Training					27,792	27,792		27,792			13
14	Program Transportation			40,832	40,832		40,832		40,832			14
15	Other (specify):* Day Training	330,864	18,724	506,911	856,499		856,499	(820,977)	35,522			15
16	TOTAL Health Care and Programs	3,017,772	88,433	609,218	3,715,423		3,715,423	(820,977)	2,894,446			16
	C. General Administration											
17	Administrative	87,750	21,958		109,708	(34,384)	75,324		75,324			17
18	Directors Fees											18
19	Professional Services			123,106	123,106		123,106		123,106			19
20	Dues, Fees, Subscriptions & Promotions			13,308	13,308		13,308		13,308			20
21	Clerical & General Office Expenses	315,892	8,347		324,239		324,239		324,239			21
22	Employee Benefits & Payroll Taxes			691,776	691,776		691,776	(35,522)	656,254			22
23	Inservice Training & Education											23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice											26
27	Other (specify):*											27
28	TOTAL General Administration	403,642	30,305	828,190	1,262,137	(34,384)	1,227,753	(35,522)	1,192,231			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,200,148	312,039	1,663,194	6,175,381	(34,384)	6,140,997	(1,720,949)	4,420,048			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Mount St Joseph #0005520 **Report Period Beginning:** 7/1/2015 **Ending:** 6/30/2016

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			1,450,165	1,450,165		1,450,165	81,009	1,531,174			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			100,938	100,938		100,938	(100,938)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			240,000	240,000		240,000	(240,000)				34
35	Rent-Equipment & Vehicles					34,384	34,384		34,384			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,791,103	1,791,103	34,384	1,825,487	(259,929)	1,565,558			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			349,780	349,780		349,780		349,780			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			349,780	349,780		349,780		349,780			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,200,148	312,039	3,804,077	8,316,264		8,316,264	(1,980,878)	6,335,386			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 Mount St Joseph # 0005520 Report Period Beginning: 7/1/2015 Ending: 6/30/2016

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				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$		$	30

BHF USE ONLY								
48		49		50		51		52	

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

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

Mount St Joseph

ID# 0005520

Report Period Beginning: 7/1/2015

Ending: 6/30/2016

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3	Governmental Sponsored Programs	(34,442)	K1 & K2	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23	Developmental Day Training	(820,977)	K15	23
24	Payroll Tax Day Training	(35,522)	K22	24
25				25
26				26
27				27
28				28
29	Utilities	(9,031)	K5	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**	(899,972)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Mount St Joseph **#** 0005520 **Report Period Beginning:** 7/1/2015 **Ending:** 6/30/2016

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	(18,403)	0	0	0	0	0	0	0	0	0	0	(18,403)	1
2	Food Purchase	(16,039)	0	0	0	0	0	0	0	0	0	0	(16,039)	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	(9,031)	0	0	0	0	0	0	0	0	0	0	(9,031)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):* Day Training	(820,977)	0	0	0	0	0	0	0	0	0	0	(820,977)	7
8	**TOTAL General Services**	(864,450)	0	0	0	0	0	0	0	0	0	0	(864,450)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	(35,522)	0	0	0	0	0	0	0	0	0	0	(35,522)	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**	(35,522)	0	0	0	0	0	0	0	0	0	0	(35,522)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(899,972)	0	0	0	0	0	0	0	0	0	0	(899,972)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Mount St Joseph # 0005520 **Report Period Beginning:** 7/1/2015 **Ending:** 6/30/2016

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	81,009	0	0	0	0	0	0	0	0	0	81,009	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	(100,938)	0	0	0	0	0	0	0	0	0	(100,938)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(240,000)	0	0	0	0	0	0	0	0	0	(240,000)	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	(259,929)	0	0	0	0	0	0	0	0	0	(259,929)	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)**	(899,972)	(259,929)	0	0	0	0	0	0	0	0	0	(1,159,901)	45

Facility Name & ID Number Mount St Joseph # 0005520 Report Period Beginning: 7/1/2015 Ending: 6/30/2016

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Daughters of St Mary of Providence	100					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

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

1 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		Rent	$ 240,000	Daughters of St Mary of Providence	100.00%	$	$ (240,000)	1
2	V		Depreciation	(81,009)	Daughters of St Mary of Providence	100.00%		81,009	2
3	V		Interest	100,938	Daughters of St Mary of Providence	100.00%		(100,938)	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			$ 259,929			$	$ * (259,929)	14

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

Facility Name & ID Number Mount St Joseph # 0005520 Report Period Beginning: 7/1/2015 Ending: 6/30/2016

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 Mount St Joseph # 0005520 Report Period Beginning: 7/1/2015 Ending: 6/30/2016

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Sister Lucy Tardivo	Superior	C.E.O.	0.00		84	100.00	Stipend	$ 58,500	L17C1	1
2	Sister Janet Kosman	Administrator	Director	0.00		84	100.00	Stipend	29,250	L17C1	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 87,750		13

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

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

Facility Name & ID Number Mount St Joseph # 0005520 Report Period Beginning: 7/1/2015 Ending: 6/30/2016

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										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 Mount St Joseph # 0005520 Report Period Beginning: 7/1/2015 Ending: 6/30/2016

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	Daughters of St Mary of Provid	X		St Clare Cottage Construction	$10,000.00	9/21/2012	$ 5,835,958	$ 1,620,479	N/A	0.0600	$ 100,938	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$10,000.00		$ 5,835,958	$ 1,620,479			$ 100,938	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 5,835,958	$ 1,620,479			$ 100,938	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 Mount St Joseph # 0005520 Report Period Beginning: 7/1/2015 Ending: 6/30/2016

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ N/A	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$ N/A	3
4. Real Estate Tax accrual used for 2016 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.		$ Tax Exempt	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2011		8
	2012		9
	2013		10
	2014		11
	2015		12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015	$	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.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Mount St Joseph COUNTY Lake

FACILITY IDPH LICENSE NUMBER 0005520

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2015 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 2015.

	(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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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 Mount St Joseph # 0005520 Report Period Beginning: 7/1/2015 Ending: 6/30/2016

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 168,131 B. General Construction Type: Exterior Brick Frame Brick Number of Stories 2

C. Does the Operating Entity? [ ] (a) Own the Facility [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).

Developmental Training 1,010 Square Feet

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

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Home	6,969,600	1935	$ 8,000	1
2					2
3	TOTALS	6,969,600		$ 8,000	3

Facility Name & ID Number Mount St Joseph # 0005520 Report Period Beginning: 7/1/2015 Ending: 6/30/2016

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	129			1969	$ 5,011,610	$ 1,317,060		$ 1,317,060	$	$ 12,545,919	4
5											5
6				1990	2,361,653	78,720		78,720		2,086,082	6
7				1990	68,729	2,289		2,289		60,679	7
8											8
	Improvement Type**										
9	Land Development - Prior Years			1993	29,005						9
10				1994	93,489						10
11				1995	44,713						11
12				1996	18,082						12
13				1997	42,570						13
14				1998	17,423						14
15				1999	21,853						15
16				2001	4,700						16
17				2005	22,748						17
18				2006	12,917						18
19				2007	82,454						19
20	Building Improvement - Prior Years			1991	74,205						20
21				1992	90,293						21
22				1993	180,181						22
23				1994	178,251						23
24				1995	231,228						24
25				1996	82,875						25
26				1997	71,814						26
27				1998	116,448						27
28				1999	121,823						28
29				2000	37,015						29
30				2001	76,812						30
31				2002	112,086						31
32				2003	250,123						32
33				2004	402,099						33
34				2005	661,395						34
35				2006	964,742						35
36				2007	667,688						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 Mount St Joseph # 0005520 Report Period Beginning: 7/1/2015 Ending: 6/30/2016

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	Land Improvements		$	$		$	$	$	37
38	Prior Year	2008	156,512						38
39		2009	157,759						39
40	6 Sandstone Bases & Crosses	11/24/2010	2,922						40
41	Repave Parking Lots	9/6/2012	149,300						41
42	Moselle - sand filter rework for septic system renovation	11/3/2014	45,250						42
43	Everlasting Memorials	2/11/2015	3,509						43
44									44
45	Building Improvements								45
46	Prior Year	2008	1,945,635						46
47		2009	351,662						47
48		2010	1,548,258						48
49		2011	455,061						49
50		2012	9,478,660						50
51	Chapel Window Replacement - Payment to NEPCO	1/15/2013	62,000						51
52	Chapel Window Replacement - Payment to NEPCO	1/31/2013	106,832						52
53	Dry Sprinkler Replacement	3/19/2013	15,480						53
54	St Rose Sprinkler Replacement	3/19/2013	4,500						54
55	Chapel Window Replacement - Payment to NEPCO	3/31/2013	152,855						55
56	Chapel Heater Replacement	4/3/2013	5,100						56
57	Decorative Pole Light	5/3/2013	2,600						57
58	Chapel Renovation - Payment to NEPCO	10/31/2013	147,308						58
59	Priest House Renovation	1/23/2014	40,000						59
60	Priest House Light Pole and Fixture	1/29/2014	5,100						60
61	Guanella Hall Renovation	2/3/2014	4,569,130						61
62	Chairs and Tables	2/7/2014	5,950						62
63	Ceiling Fixtures and Lights	3/10/2014	1,269						63
64	Shielding Cable & Annunciators	3/12/2014	3,820						64
65	Annunciator Panel and Lock	3/28/2014	1,620						65
66	Roof Replacement	7/9/2014	3,995						66
67	Angel Guardian Roofing	7/10/2014	36,450						67
68	Angel Guardian Roofing	7/11/2014	36,527						68
69	Chapel Bathroom Renovation	7/31/2014	5,500						69
70	TOTAL (lines 4 thru 69)		$ 31,651,588	$ 1,398,069		$ 1,398,069	$	$ 14,692,680	70

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

Facility Name & ID Number Mount St Joseph # 0005520 Report Period Beginning: 7/1/2015 Ending: 6/30/2016

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		$ 31,651,588	$ 1,398,069		$ 1,398,069	$	$ 14,692,680	1
2	Boiler Replacement	10/27/2014	8,260						2
3	Campus Network Infrastructure Installation	9/14/2015	133,478						3
4	Nursing Station Windows	10/2/2015	47,282						4
5	Gazebo Screens	10/7/2015	11,250						5
6	St Joseph Hall Renovation	10/25/2015	5,687,799						6
7	NEPCO - Asphault Repair & Sealing	11/10/2015	154,000						7
8	Campus Network Infrastructure Installation	11/25/2015	106,782						8
9	Heat Exchangers	1/29/2016	10,600						9
10	Campus Network Infrastructure Installation	2/15/2016	25,792						10
11	EM Lighting	4/5/2016	9,750						11
12	Nelson Fire Protection - Sacred Heart Sprinklers	4/8/2016	4,462						12
13	Tabernacle Refinish	4/22/2016	1,656						13
14	NEPCO - Water Level Monitor	5/2/2016	3,200						14
15	NEPCO - Conduit Repairs and Replacement	5/4/2016	42,000						15
16	NEPCO - EM Lighting for St Clare	5/10/2016	14,950						16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 37,912,849	$ 1,398,069		$ 1,398,069	$	$ 14,692,680	34

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

Facility Name & ID Number Mount St Joseph # 0005520 Report Period Beginning: 7/1/2015 Ending: 6/30/2016

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	$ 2,305,130	$ 87,990	$ 87,990	$		$ 1,622,645	71
72	Current Year Purchases	60,022						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 2,365,152	$ 87,990	$ 87,990	$		$ 1,622,645	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				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	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)	$ 40,286,001	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 1,486,059	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 1,486,059	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 16,315,325	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Farm Equipment	$ 40,316	$	$ 40,316	86
87	Vehicles	443,443	38,038	208,828	87
88	Non-Care	1,134,636	7,077	1,074,382	88
89					89
90					90
91	TOTALS	$ 1,618,395	$ 45,115	$ 1,323,526	91

G. Construction-in-Progress

	Description	Cost	
92	New Well	$ 641,523	92
93			93
94			94
95		$ 641,523	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 Mount St Joseph # 0005520 Report Period Beginning: 7/1/2015 Ending: 6/30/2016

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

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.	/2017	$
13.	/2018	$
14.	/2019	$

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: $ 34,384 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 Mount St Joseph # 0005520 Report Period Beginning: 7/1/2015 Ending: 6/30/2016

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					
3	Classroom Wages	(a)		9,264		9,264
4	Clinical Wages	(b)		18,528		18,528
5	In-House Trainer Wages	(c)				
6	Transportation					
7	Contractual Payments					
8	CNA Competency Tests					
9	TOTALS		$	$ 27,792	$	$ 27,792
10	SUM OF line 9, col. 1 and 2	(e)	$ 27,792			

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	24
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	24

(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	L9,C3	12 visits	36,000				12	36,000	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			$ 36,000		$	$	12	$ 36,000	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 Mount St Joseph **#** 0005520 **Report Period Beginning:** 7/1/2015 **Ending:** 6/30/2016

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 6/30/2016 **(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	$ 3,044,020	$ 3,044,020	1
2	Cash-Patient Deposits	89,315	89,315	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	660,133	660,133	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	80,471	80,471	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Interest In Trust - Current	1,988,144	1,988,144	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 5,862,083	$ 5,862,083	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	16,207	16,207	12
13	Land		8,000	13
14	Buildings, at Historical Cost		7,437,391	14
15	Leasehold Improvements, at Historical Cost	22,696,991	31,455,586	15
16	Equipment, at Historical Cost		3,003,419	16
17	Accumulated Depreciation (book methods)		(17,638,851)	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): Interest In Trust - LT	1,528,742	1,528,742	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 24,241,940	$ 25,810,494	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 30,104,023	$ 31,672,577	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 303,025	$ 303,025	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	89,315	89,315	28
29	Short-Term Notes Payable	120,000	120,000	29
30	Accrued Salaries Payable	339,226	339,226	30
31	Accrued Taxes Payable (excluding real estate taxes)	29,701	29,701	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 881,267	$ 881,267	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,500,479	1,500,479	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)**	$ 1,500,479	$ 1,500,479	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,381,746	$ 2,381,746	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 27,722,277	$ 29,290,831	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 30,104,023	$ 31,672,577	48

***(See instructions.)**

Facility Name & ID Number Mount St Joseph # 0005520 Report Period Beginning: 7/1/2015 Ending: 6/30/2016

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 28,984,642	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 28,984,642	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,262,365)	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)**	$ (1,262,365)	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)**	$ 27,722,277	24 *

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

Facility Name & ID Number Mount St Joseph # 0005520 Report Period Beginning: 7/1/2015 Ending: 6/30/2016

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	$ 5,809,328	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,809,328	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions	563,964	24
25	Interest and Other Investment Income***	54,746	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 618,710	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	Developmental Day Training	625,861	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 625,861	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,053,899	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,197,821	31
32	Health Care	3,715,423	32
33	General Administration	3,053,240	33
	B. Capital Expense		
34	Ownership		34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	349,780	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,316,264	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,262,365)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,262,365)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 4,379,505	44
45	Private Pay - Net Inpatient Revenue	106,440	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) SSA/SSI	1,323,383	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,809,328	49

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

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

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

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

Facility Name & ID Number Mount St Joseph # 0005520 Report Period Beginning: 7/1/2015 Ending: 6/30/2016

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing			$	$	1
2	Assistant Director of Nursing					2
3	Registered Nurses	18,677	19,931	493,481	24.76	3
4	Licensed Practical Nurses	8,335	8,895	174,866	19.66	4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	3,613	3,855	86,550	22.45	9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	2,018	2,153	39,078	18.15	13
14	Head Cook	5,342	5,700	75,245	13.20	14
15	Cook Helpers/Assistants	7,017	7,488	69,709	9.31	15
16	Dishwashers					16
17	Maintenance Workers	12,413	13,246	214,326	16.18	17
18	Housekeepers	30,139	32,161	338,017	10.51	18
19	Laundry	4,338	4,629	42,359	9.15	19
20	Administrator	4,410	4,706	75,300	16.00	20
21	Assistant Administrator	5,134	5,478	63,000	11.50	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	15,889	16,955	265,342	15.65	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	9,822	10,481	201,445	19.22	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	147,030	156,896	1,730,566	11.03	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Day Training	25,838	27,572	330,864	12.00	33
34	TOTAL (lines 1 - 33)	300,015	320,146	$ 4,200,148 *	$ 13.12	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	130	$ 6,500	L1, C3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	15	921	L10, C3	45
46	Other(specify) Dentist	34	1,700	L10, C3	46
47	Psychiarist	21	6,375	L10, C3	47
48					48
49	TOTAL (lines 35 - 48)	200	$ 15,496		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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 Mount St Joseph # 0005520 Report Period Beginning: 7/1/2015 Ending: 6/30/2016

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Sister Lucy Tardivo	Superior		$ 58,500
Sister Janet Kosman	Administrator		29,250
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 87,750

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
AmCheck	Payroll	$ 21,778
BIK & Co	Auditors	21,000
Michael Sullivan	Accounting	59,875
Q3 Consulting	IT	20,453
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 123,106

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 174,569
Unemployment Compensation Insurance	74,496
FICA Taxes	326,574
Employee Health Insurance	
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Pension	116,137
Day Training Payroll Tax	(35,522)
TOTAL (agree to Schedule V, line 22, col.8)	$ 656,254

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

Description	Line #	Amount
		$
TOTAL		$ 0

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
Licenses & Fees	6,443
Dues & Subscriptions	6,865
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 13,308

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 0
In-State Travel	0
Seminar Expense	0
Entertainment Expense	(0)
TOTAL (agree to Sch. V, line 24, col. 8)	$ 0

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Mount St Joseph # 0005520 Report Period Beginning: 7/1/2015 Ending: 6/30/2016

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.

(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?

(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 Yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **45,183** Line **L10**

(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.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **349,780**
This amount is to be recorded on line 42 of Schedule V.

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

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

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **Yes** 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. $ **N/A** 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? **No**
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. $ **0**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
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? **Yes**
g. Does the facility transport residents to and from day training? Yes
Indicate the amount of income earned from providing such transportation during this reporting period. $ **0**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **BIK & CO, LLP**

(18) Have all costs which do not relate to the provision of long term care been adjusted 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. **N/A**
Attach invoices and a summary of services for all architect and appraisal fees

V. COST CENTER EXPENSES RECLASSIFICATION PAGE 3

FROM	V. LINE 10	$ (27,792)
TO	V. LINE 13	$ 27,792
	TO RECLASSIFY NURSE AIDE TRAINING	

FROM	V. LINE 17	$ (34,384)
TO	V. LINE 35	$ 34,384
	TO RECLASSIFY RENT-EQUIPMENT	

LINE 15 PAGE 3

DAY TRAINING	SALARIES			$ 487,514	
DAY TRAINING	SUPPLIES			$ 18,724	
DAY TRAINING	BENEFITS		0	$ 34,672	
DAY TRAINING	PROFESSIONAL FEES		0	$ 4,693	
DAY TRAINING	OCCUPANCY		0	$ 75,699	
DAY TRAINING	TRANSPORT		0	$ 5,306	
DAY TRAINING	RENT		0	$ 27,600	
DAY TRAINING	DEPRECIATION		0	$ 166,769	
DAY TRAINING	EDUCATIONAL		0	$ -	
	SUB-TOTAL			$ -	$ 820,977
DAY TRAINING	P/R TAX	LINE 22 PAGE 3			$ 35,522
	TOTAL				$ 856,499

VI. ADJUSTMENT DETAIL PAGE 5

NON-ALLOWABLE EXPENSES

DIETARY	VI. LINE 1	X .10 =	$ 18,403	
FOOD PURCHASE	V. LINE 2	X .10 =	$ 16,039	$ 34,442
DEPRECIATION	V. LINE 30			$ 81,009
DAY TRAINING	V. LINE 15			$ 820,977
DAY TRAINING P/R TAX	V. LINE 22			$ 35,522
UTILITIES	V. LINE 5			$ 9,031
SUB-TORAL (A):				$ 980,981
RELATED PARTIES	VII. LINE 14			$ -
TOTAL ADJUSTMENTS (A) AND (B)				$ 980,981

V. ADJUSTMENT DETAIL/UTILITIES PAGE 5 SQUARE FOOTAGE

CARE RELATED AREAS;

THERAPEUTIC CENTER	22,122
JOSEPH,S	9,464
OLD NURSES STATION TO KITCHEN PASSAGEWAY	6,770
PASSAGEWAY	6,947
ADMINISTRATIVE BUILDING	6,890
ST. ALIYIOUS	9,270
NOVITIATE & AUDITORIUM	11,120
GUANELLA	15,887
ANGEL GUARDIAN	9,582
KITCHEN	5,749
BOILER & LAUNDRY	4,690
GARAGE	660
CHAPEL	12,468
CHAPLAIN.S HOUSE	4,022
GARAGE	1,012
ADMON BUILDING 2nd FLOOR	3,445
ST. MARY,S	11,691
ST. CLAIR.S	19,014
TOTAL..	160,803

NON-CARE RELATED AREAS:

NOVITIATE & AUDITORIUM	5,560
FARM HOUSE	1,768
TOTAL	7,328
TOTAL SQUARE FOOTAGE	168,131

NON-CARE AREAS 7,328/168,131 .O4

TOTAL UTILITIES LINE 5 PAGE 3	$ 225,786
	X.O4 =
TOTAL NON-CARE RELATED UTILITIES	$ 9,031

XVII. INCOME STATEMENT OTHER REVENUE	PAGE 19	$ -
DEVELOPMENTAL DAY TRAINING	LINE 28a	$ 625,861
XVIII. A. STAFFING & SALARY COSTS	PAGE 20	$ 4,200,148
DEVELOPMENTAL DAY TRAINING	LINE 33	$ 330,864
XX. GENERAL INFORMATION	PAGE 23	