FOR BHF USE

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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: 0005637

Facility Name: ST JOSEPH NURSING HOME

Address: 401 9TH STREET (Number) LACON (City) 61540 (Zip Code)

County: MARSHALL

Telephone Number: (309) 246-2175 **Fax #** (309) 246-2299

HFS ID Number:

Date of Initial License for Current Owners: 1964

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Boris Kushnir **Telephone Number:** (305) 819-9555
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) _____ (Date)
(Type or Print Name) SISTER LORETTA MATAS
(Title) PRESIDENT

Paid Preparer

(Signed) _____ 11/17/2016 (Date)
(Print Name and Title) BORIS KUSHNIR, SENIOR MANAGER
(Firm Name & Address) MOORE STEPHENS LOVELACE, PA, 701 BRICKELL AVE., SUITE 550, MIAMI, FL 33131
(Telephone) (305) 819-9555 Fax # (305)351-0002

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

Facility Name & ID Number ST JOSEPH NURSING HOME # 0005637 Report Period Beginning: 7/1/2015 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	93	Skilled (SNF)	93	34,038	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	93	TOTALS	93	34,038	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	13,424	10,213	1,986	25,623	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,424	10,213	1,986	25,623	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 75.28%

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

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Headstart and Sherriff's Department

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

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

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

I. On what date did you start providing long term care at this location?
Date started 5/7/1965

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 93 and days of care provided 1,884

Medicare Intermediary NGS

IV. ACCOUNTING BASIS

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

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

Tax Year: 7/1/15-6/30/16 Fiscal Year: 7/1/15-6/30/16

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

Facility Name & ID Number ST JOSEPH NURSING HOME # 0005637 Report Period Beginning: 7/1/2015 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	269,937		34,633	304,570		304,570	(31,235)	273,335			1
2	Food Purchase		227,347		227,347		227,347	(79,003)	148,344			2
3	Housekeeping	76,222	20,355		96,577		96,577		96,577			3
4	Laundry	58,724		1,647	60,371		60,371		60,371			4
5	Heat and Other Utilities			99,651	99,651		99,651	(3,684)	95,967			5
6	Maintenance	82,970		33,644	116,614		116,614		116,614			6
7	Other (specify):*											7
8	**TOTAL General Services**	487,853	247,702	169,575	905,130		905,130	(113,922)	791,208			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,693,041	69,478	7,906	1,770,425		1,770,425		1,770,425			10
10a	Therapy			247,520	247,520		247,520		247,520			10a
11	Activities	101,786	1,323	3,065	106,174		106,174		106,174			11
12	Social Services	41,359	230	2,550	44,139		44,139		44,139			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,836,186	71,031	261,041	2,168,258		2,168,258		2,168,258			16
	C. General Administration											
17	Administrative	77,021			77,021		77,021		77,021			17
18	Directors Fees											18
19	Professional Services			94,020	94,020		94,020		94,020			19
20	Dues, Fees, Subscriptions & Promotions			4,558	4,558		4,558	(9,357)	(4,799)			20
21	Clerical & General Office Expenses	200,324	15,535	32,501	248,360		248,360	(10,365)	237,995			21
22	Employee Benefits & Payroll Taxes			583,841	583,841		583,841	(6,213)	577,628			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,484	4,484		4,484		4,484			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			50,451	50,451		50,451		50,451			26
27	Other (specify):*											27
28	**TOTAL General Administration**	277,345	15,535	769,855	1,062,735		1,062,735	(25,935)	1,036,800			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,601,384	334,268	1,200,471	4,136,123		4,136,123	(139,857)	3,996,266			29

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

Facility Name & ID Number ST JOSEPH NURSING HOME #0005637 Report Period Beginning: 7/1/2015 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			48,553	48,553		48,553		48,553			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			21,040	21,040		21,040	(21,040)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*			27,954	27,954		27,954	(28,667)	(713)			36
37	**TOTAL Ownership**			97,547	97,547		97,547	(49,707)	47,840			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			94,212	94,212		94,212		94,212			39
40	Barber and Beauty Shops			16,823	16,823		16,823		16,823			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			196,660	196,660		196,660		196,660			42
43	Other (specify):*			216,716	216,716		216,716		216,716			43
44	**TOTAL Special Cost Centers**			524,411	524,411		524,411		524,411			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,601,384	334,268	1,822,429	4,758,081		4,758,081	(189,564)	4,568,517			45

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

Facility Name & ID Number ST JOSEPH NURSING HOME # 0005637 Report Period Beginning: 7/1/2015 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	(47,517)	2		4
5	Telephone, TV & Radio in Resident Rooms	(10,365)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(21,040)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(8,171)	2		17
18	Fines and Penalties	(27,954)	36		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	(9,357)	20		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)**	$ (124,404)		$	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))**	$ (124,404)		37

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

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

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

ST JOSEPH NURSING HOME

ID# 0005637

Report Period Beginning: 7/1/2015

Ending: 6/30/2016

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Sisters' Portion of Dietary Cost	$ (31,235)	1	1
2	Sisters' Portion of Food Cost	(23,315)	2	2
3	Sisters' Portion of Heat and Other Utilities	(3,684)	5	3
4	Sisters' Portion of Depreciation	(713)	36	4
5	Sister's Portion of Employee Benefits in Meals	(6,213)	22	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**	(65,160)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number ST JOSEPH NURSING HOME # 0005637 **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	(31,235)	0	0	0	0	0	0	0	0	0	0	(31,235)	1
2	Food Purchase	(79,003)	0	0	0	0	0	0	0	0	0	0	(79,003)	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	(3,684)	0	0	0	0	0	0	0	0	0	0	(3,684)	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**	(113,922)	0	0	0	0	0	0	0	0	0	0	(113,922)	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	(9,357)	0	0	0	0	0	0	0	0	0	0	(9,357)	20
21	Clerical & General Office Expenses	(10,365)	0	0	0	0	0	0	0	0	0	0	(10,365)	21
22	Employee Benefits & Payroll Taxes	(6,213)	0	0	0	0	0	0	0	0	0	0	(6,213)	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**	(25,935)	0	0	0	0	0	0	0	0	0	0	(25,935)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(139,857)	0	0	0	0	0	0	0	0	0	0	(139,857)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number ST JOSEPH NURSING HOME # 0005637 **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	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(21,040)	0	0	0	0	0	0	0	0	0	0	(21,040)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	(28,667)	0	0	0	0	0	0	0	0	0	0	(28,667)	36
37	**TOTAL Ownership**	(49,707)	0	0	0	0	0	0	0	0	0	0	(49,707)	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)**	(189,564)	0	0	0	0	0	0	0	0	0	0	(189,564)	45

Facility Name & ID Number ST JOSEPH NURSING HOME # 0005637 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
THIS WORKSHEET IS NOT APPLICABLE						

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

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

Facility Name & ID Number ST JOSEPH NURSING HOME # 0005637 Report Period Beginning: 7/1/2015 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	THIS WORKSHEET IS NOT APPLICABLE							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 ST JOSEPH NURSING HOME # 0005637 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	THIS WORKSHEET IS NOT APPLICABLE								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

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

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

Facility Name & ID Number ST JOSEPH NURSING HOME # 0005637 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		THIS WORKSHEET IS NOT APPLICABLE								2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number ST JOSEPH NURSING HOME # 0005637 Report Period Beginning: 7/1/2015 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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Bank of Lacon		X	Working Capital	$1,484.03	11/15/13	$ 400,000	$ 357,715	11/15/17	4.0000	$ 21,040	1
2	Sisters of St Francis of Assisi	X		Working Capital	$1,000.00	7/14/14	150,000	150,000	N/A	NONE		2
3	Sisters of St Francis of Assisi	X		Working Capital	None	2/17/15	80,000		2/17/16	1.2500		3
4	Sisters of St Francis of Assisi	X		Working Capital	None	4/22/15	150,000	150,000	4/22/17	1.2500		4
5	Sisters of St Francis of Assisi	X		Working Capital	None	2/23/16	241,000	241,000	2/23/16	1.2500		5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$2,484.03		$ 1,021,000	$ 898,715			$ 21,040	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 1,021,000	$ 898,715			$ 21,040	15

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

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

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

Facility Name & ID Number ST JOSEPH NURSING HOME # 0005637 Report Period Beginning: 7/1/2015 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.**	$	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 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.	$	7

Real Estate Tax History:

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

THIS WORKSHEET IS NOT APPLICABLE

	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 ST JOSEPH NURSING HOME COUNTY MARSHALL

FACILITY IDPH LICENSE NUMBER 0005637

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 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.	THIS WORKSHEET IS NOT APPLICABLE		$	$
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 ST JOSEPH NURSING HOME # 0005637 Report Period Beginning: 7/1/2015 Ending: 6/30/2016

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 66,656 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories ONE

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

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

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

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

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

NOT APPLICABLE

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

1. Total Amount Incurred: NOT APPLICABLE 2. Number of Years Over Which it is Being Amortized: NOT APPLICABLE

3. Current Period Amortization: NOT APPLICABLE 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	OWNED BY DAUGHTERS			$	1
2	OF ST. FRANCIS OF ASSISI	428,532	1965	25,700	2
3	TOTALS	428,532		$ 25,700	3

Facility Name & ID Number ST JOSEPH NURSING HOME # 0005637 Report Period Beginning: 7/1/2015 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	43		1965		$ 465,065	$	50	$	$	$ 465,065	4
5	50		1969		898,293	17,966	50	17,966		826,429	5
6			1968		395,224		25			395,224	6
7			1986		9,717		12			9,717	7
8			2010		5,818	388	15	388		2,715	8
	Improvement Type**										
9	MISC			1968	6,160	123	50	123		5,913	9
10	GARAGE			1972	2,491	50	50	50		2,192	10
11	FINISH BASEMENT			1973	6,343	127	50	127		5,455	11
12	WINDOW			1974	900	18	50	18		756	12
13	INSULATION			1976	21,986	440	50	440		17,589	13
14	ROOF			1980	16,049	321	50	321		11,555	14
15	MISC REMODELING			1981	7,711		10			7,711	15
16	ADPA AUDIT ADJUSTMENTS			1982	351,694		10			351,694	16
17	DECORATING			1987	3,285		10			3,285	17
18	PARKING LOT			1988	19,937		10			19,937	18
19	FIRE ALARM SYSTEM			1990	37,956		10			37,956	19
20	NEW ROOF			1992	55,787		10			55,787	20
21	HOT WATER TANK			1992	3,295		10			3,295	21
22	BUILDING PAINTING			1993	7,336		5			7,336	22
23	ROOF REPAIDS			1993	434		10			434	23
24	WATER HEATER			1993	223		15			223	24
25	BOILER REPAID			1993	1,415		10			1,415	25
26	CODE ALERT FIRE SYSTEM			1995	8,559		10			8,559	26
27	MISC			1997	3,013		10			3,013	27
28	VINYL FLOOR			1998	4,012		5			4,012	28
29	CERAMIC FLOOR FOR NEW TUB			1999	107	5	20	5		84	29
30	CARPET ON WALLS			2000	2,668		5			2,668	30
31	METAMORA TELEPHONE SYSTEM			2000	7,337		10			7,337	31
32	TOMKAT ROOFING			2001	18,760		10			18,760	32
33	HOBERT CORP			2001	1,555		10			1,555	33
34	ASPHALT REPAID			2002	2,900		8			2,900	34
35	75 GALLON 365M ASME WTR HTR			2006	5,225	523	10	523		4,966	35
36	ULTRA CARE 709 BED LAMINATE PANELS			2006	5,809	387	15	387		3,677	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number ST JOSEPH NURSING HOME # 0005637 Report Period Beginning: 7/1/2015 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	HOYER PROF PATIENT LIFT	2006	$ 3,020	$ 302	10	$ 302	$	$ 2,869	37
38	HOYER PROF VERTICAL PATIENT LIFT W/SCALE	2006	4,249	425	10	425		4,033	38
39	CONCRETE SIDEWALK	2007	5,220	348	15	348		2,958	39
40	ROOFING	2007	20,986	2,099	10	2,099		17,836	40
41	FIRE DAMPERS	2007	13,100	873	15	873		7,425	41
42	BEDS (16)	2007	19,904	1,327	15	1,327		11,283	42
43	DOOR ALARM SYSTEM	2007	20,963	1,398	15	1,398		11,881	43
44	EQUIPMENT - NURSING SERVICE	2008	21,360	1,424	15	1,424		9,475	44
45	KITCHEN SUPPRESSION HOOD	2010	3,321	110	5	110		3,431	45
46	MODIFY GAS PIPING TO KITCHEN	2010	1,585	79	5	79		1,664	46
47	AIR CONDITIONING UNIT	2011	45,717	2,286	20	2,286		13,715	47
48	MEDICAL EQUIPMENT -DEFIBRILATOR	2011	1,562	156	10	156		937	48
49	LOUNGE REMODEL: WALL REPAID AND PAINT	2012	1,100	110	10	110		550	49
50	LOUNGE REMODEL: FLOORING (CARPETING) INSTALL	2012	3,465	173	20	173		866	50
51	REHAB ROOM UPGRADE: PAINT, VINLY FLOOR & PURCH	2012	4,344	434	10	434		2,171	51
52	WATER HEATER AND BOOSTER	2012	4,817	241	20	241		1,205	52
53	DINING ROOM LIGHTS	2013	1,137	114	10	114		455	53
54	DINING ROOM DOOR	2013	7,445	745	10	745		2,668	54
55	LAND IMPROVEMENTS - EARTHWORK, PLANTS, MOBILA	2013	7,510	751	10	751		2,316	55
56	ADJUSTMENT FOR PY DEPRECIATION							31,446	56
57	Chapel Flooring and Painting	2014	19,580	783	25	783		2,219	57
58	Synthetic Wall Guard-Whole Facility (Lower Wall Covering)	2014	36,550	1,462	25	1,462		4,264	58
59	Concrete Flooring-External-Memorial Garden Patio	2014	35,808	2,387	15	2,387		6,962	59
60	Garage Roof Replacement	2015	1,250	125	10	125		135	60
61	Ice Machine Compressor Replacement	2015	650	130	5	130		141	61
62	WATER HEATER	2016	7,656	383	5	383		383	62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,669,363	$ 39,013		$ 39,013	$	$ 2,432,502	70

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

Facility Name & ID Number ST JOSEPH NURSING HOME # 0005637 Report Period Beginning: 7/1/2015 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	$ 317,142	$ 9,730	$ 9,730	$		$ 197,613	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	488,139					488,139	73
74								74
75	TOTALS	$ 805,281	$ 9,730	$ 9,730	$		$ 685,752	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	NURSING HOME USE	CHEVY CAPRICE & PICKUP	1987	$ 24,879	$	$	$		$ 24,879	76
77	NURSING HOME USE	MISC. OTHER	VARIOUS	9,476					9,476	77
78	NURSING HOME USE	2008 MED DUTY VEHICLE	2008	46,866					46,866	78
79										79
80	TOTALS			$ 81,221	$	$	$		$ 81,221	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,581,565	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 48,743	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 48,743	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)	$ 3,199,475	85	

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	SISTERS' SHARE OF BUILDING	$ 63,491	$	$ 63,491	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 63,491	$	$ 63,491	91

G. Construction-in-Progress

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

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

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

Facility Name & ID Number ST JOSEPH NURSING HOME # 0005637 Report Period Beginning: 7/1/2015 Ending: 6/30/2016

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: THIS WORKSHEET IS NOT APPLICABLE

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
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: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number ST JOSEPH NURSING HOME # 0005637 Report Period Beginning: 7/1/2015 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?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$ NONE

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number ST JOSEPH NURSING HOME # 0005637 Report Period Beginning: 7/1/2015 Ending: 6/30/2016

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits		THIS WORKSHEET IS NOT APPLICABLE			#VALUE!		5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$		$	$	#VALUE!	$	14

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

STATE OF ILLINOIS

Facility Name & ID Number ST JOSEPH NURSING HOME **#** 0005637 **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	$ 440,490	$	1
2	Cash-Patient Deposits	7,678		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	114,865		3
4	Supply Inventory (priced at)	15,426		4
5	Short-Term Investments			5
6	Prepaid Insurance	9,534		6
7	Other Prepaid Expenses	2,905		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	506,821		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,097,719	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	122,321		13
14	Buildings, at Historical Cost	1,542,375		14
15	Leasehold Improvements, at Historical Cost	988,984		15
16	Equipment, at Historical Cost	901,950		16
17	Accumulated Depreciation (book methods)	(3,199,475)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	61,756		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 417,911	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,515,630	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 536,732	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	156,568		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	FNB - Line of Credit	357,715		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,051,015	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	541,000		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)**	$ 541,000	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,592,015	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (76,385)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,515,630	$	48

***(See instructions.)**

Facility Name & ID Number ST JOSEPH NURSING HOME # 0005637 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**	$ (141,883)	1
2	Restatements (describe):		2
3		(34,389)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (176,272)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	36,154	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	63,733	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)**	$ 99,887	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)**	$ (76,385)	24 *

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

Facility Name & ID Number ST JOSEPH NURSING HOME # 0005637 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	$ 5,500,935	1
2	Discounts and Allowances for all Levels	(976,773)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,524,162	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	306	12
13	Barber and Beauty Care	16,212	13
14	Non-Patient Meals	47,211	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	2,158	18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	6,013	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 71,900	23
	D. Non-Operating Revenue		
24	Contributions	174,968	24
25	Interest and Other Investment Income***	23,205	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 198,173	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,794,235	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	905,130	31
32	Health Care	2,168,258	32
33	General Administration	1,062,735	33
	B. Capital Expense		
34	Ownership	97,547	34
	C. Ancillary Expense		
35	Special Cost Centers	111,035	35
36	Provider Participation Fee	196,660	36
	D. Other Expenses (specify):		
37	Bad Debt Expense	216,716	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,758,081	40
41	**Income before Income Taxes (line 30 minus line 40)****	36,154	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 36,154	43

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

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

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

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

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

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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	1,900	2,080	$ 66,576	$ 32.01	1
2	Assistant Director of Nursing	0	0	0		2
3	Registered Nurses	12,163	13,194	367,145	27.83	3
4	Licensed Practical Nurses	17,441	18,621	432,984	23.25	4
5	CNAs & Orderlies	56,993	61,408	811,870	13.22	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,957	2,080	36,558	17.58	9
10	Activity Assistants	5,446	6,043	65,228	10.79	10
11	Social Service Workers	1,986	2,089	41,359	19.80	11
12	Dietician					12
13	Food Service Supervisor	1,607	1,737	30,461	17.54	13
14	Head Cook	7,544	8,393	91,244	10.87	14
15	Cook Helpers/Assistants	10,071	11,282	96,401	8.55	15
16	Dishwashers	6,146	6,443	51,831	8.04	16
17	Maintenance Workers	3,952	4,253	82,970	19.51	17
18	Housekeepers	7,947	8,737	76,222	8.72	18
19	Laundry	5,581	6,227	58,724	9.43	19
20	Administrator	2,008	2,120	77,021	36.33	20
21	Assistant Administrator					21
22	Other Administrative	1,744	1,894	41,640	21.99	22
23	Office Manager	3,015	3,293	92,295	28.03	23
24	Clerical	6,579	7,367	66,389	9.01	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,422	1,562	14,466	9.26	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	155,500	168,819	$ 2,601,384 *	$ 15.41	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	149	$ 6,996	1.1	35
36	Medical Director				36
37	Medical Records Consultant	34	2,460	10.1	37
38	Nurse Consultant				38
39	Pharmacist Consultant	96	5,446	12.1	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	29	2,550	12.1	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	308	$ 17,452		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	8	$ 280	10.1	50
51	Licensed Practical Nurses	392	13,992	10.1	51
52	Certified Nurse Assistants/Aides	287	5,665	10.1	52
53	TOTAL (lines 50 - 52)	687	$ 19,937		53

Facility Name & ID Number ST JOSEPH NURSING HOME # 0005637 Report Period Beginning: 7/1/2015 Ending: 6/30/2016

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jerlene Jamison	Administrator	0	$ 77,021
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 77,021

B. Administrative - Other

Description	Amount
THIS SCHEDULE IS NOT APPLICABLE	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Brown Smith Wallace	Auditor	$ 30,000
PointClick Care	ADT system	22,512
Facet	Computer Support	12,167
Walker Phillips	Medicare Cost	4,700
Galaxy	Payroll system	3,252
Ability	Medicare Billing / eligibility	1,956
Alliance	401K Administration	3,200
Kronos	Payroll timekeeping system	2,377
First Nat'l Bank activity	Banking	1,050
E-Health Data Solutions	Quality improvement systems	4,200
Catholic Mutual Group	Insurance consulting	4,100
Misc other	miscellaneous	4,506
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 94,020

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 96,399
Unemployment Compensation Insurance	36,679
FICA Taxes	178,915
Employee Health Insurance	266,876
Employee Meals	4,872
Illinois Municipal Retirement Fund (IMRF)*	
Employee Incentives	100
Less: Sister's Maintenance Adjustment	(6,213)
TOTAL (agree to Schedule V, line 22, col.8)	$ 577,628

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

Description	Line #	Amount
		$
THIS SCHEDULE IS NOT APPLICABLE		
TOTAL		$

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 and Fees	972
Leading Age dues credit	(5,771)
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ (4,799)

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
NONE	
In-State Travel	
Jerlene Jamison	4,094
Lauren Blough	390
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,484

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number ST JOSEPH NURSING HOME # 0005637 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? **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? **5**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **28,256** Line **10.2**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **196,660**
This amount is to be recorded on line 42 of Schedule V.

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

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

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **YES, see adj** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **NONE** Has any meal income been offset against related costs? **YES** Indicate the amount. $ **47,517**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **NONE**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **In Process**
Firm Name: **BROWN SMITH WALLACE, LLC**

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

(19) 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