FOR BHF USE

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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.

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

I. IDPH License ID Number: 0035006

Facility Name: St Patricks Residence

Address: 1400 Brookdale Road (Number) Naperville (City) 60563 (Zip Code)

County: DuPage

Telephone Number: (630) 416-6565 **Fax #** (630) 416-8755

HFS ID Number:

Date of Initial License for Current Owners:

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: Deborah D. Freeland **Telephone Number:** (317) 569-6230
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 01/01/2016 to 12/31/2016 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) Marilyn Daley
(Title) Administrator

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) Deborah D. Freeland, CPA, Principal
(Firm Name & Address) CliftonLarsonAllen LLP, 9365 Counselors Row, Suite 200 Indianapolis, IN 46240
(Telephone) (317) 574-9100 Fax # (317) 574-9707

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 Patricks Residence # 0035006 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	206	Skilled (SNF)	206	75,396	1
2		Skilled Pediatric (SNF/PED)			2
3	3	Intermediate (ICF)	3	1,098	3
4		Intermediate/DD			4
5	1	Sheltered Care (SC)	1	366	5
6		ICF/DD 16 or Less			6
7	210	TOTALS	210	76,860	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	31,266	29,332	4,473	65,071	8
9	SNF/PED					9
10	ICF	19	986		1,005	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	31,285	30,318	4,473	66,076	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.97%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

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

F. Does the facility maintain a daily midnight census? No

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 5/22/1989

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 5/22/1989 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 206 and days of care provided 4,473

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/16 Fiscal Year: 12/31/16

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

Facility Name & ID Number St Patricks Residence # 0035006 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	940,401	51,347	20,747	1,012,495		1,012,495		1,012,495			1
2	Food Purchase		489,333		489,333		489,333	(965)	488,368			2
3	Housekeeping			785,737	785,737		785,737		785,737			3
4	Laundry											4
5	Heat and Other Utilities			334,625	334,625		334,625	(19,062)	315,563			5
6	Maintenance	300,823	57,148	64,468	422,439		422,439		422,439			6
7	Other (specify):*											7
8	**TOTAL General Services**	1,241,224	597,828	1,205,577	3,044,629		3,044,629	(20,027)	3,024,602			8
	B. Health Care and Programs											
9	Medical Director			33,366	33,366		33,366		33,366			9
10	Nursing and Medical Records	6,037,283	295,874	988,683	7,321,840		7,321,840		7,321,840			10
10a	Therapy	195,902		903,051	1,098,953		1,098,953		1,098,953			10a
11	Activities	322,769	15,779	26,209	364,757		364,757		364,757			11
12	Social Services	202,573	19,473	10,352	232,398		232,398		232,398			12
13	CNA Training											13
14	Program Transportation			2,162	2,162		2,162		2,162			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	6,758,527	331,126	1,963,823	9,053,476		9,053,476		9,053,476			16
	C. General Administration											
17	Administrative	200,186		158,868	359,054		359,054		359,054			17
18	Directors Fees											18
19	Professional Services			117,523	117,523		117,523		117,523			19
20	Dues, Fees, Subscriptions & Promotions			91,374	91,374		91,374	(1,746)	89,628			20
21	Clerical & General Office Expenses	727,232	55,493	540,937	1,323,662		1,323,662	(496,232)	827,430			21
22	Employee Benefits & Payroll Taxes			2,031,891	2,031,891		2,031,891		2,031,891			22
23	Inservice Training & Education											23
24	Travel and Seminar			5,099	5,099		5,099	(5,099)				24
25	Other Admin. Staff Transportation			13,496	13,496		13,496	(13,496)				25
26	Insurance-Prop.Liab.Malpractice			163,877	163,877		163,877		163,877			26
27	Other (specify):*											27
28	**TOTAL General Administration**	927,418	55,493	3,123,065	4,105,976		4,105,976	(516,573)	3,589,403			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	8,927,169	984,447	6,292,465	16,204,081		16,204,081	(536,600)	15,667,481			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 Patricks Residence #0035006 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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			571,992	571,992		571,992	9,256	581,248			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			571,992	571,992		571,992	9,256	581,248			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		263,448	39,834	303,282		303,282		303,282			39
40	Barber and Beauty Shops	39,526			39,526		39,526		39,526			40
41	Coffee and Gift Shops		36,396		36,396		36,396	(36,396)				41
42	Provider Participation Fee			521,608	521,608		521,608		521,608			42
43	Other (specify):*	124,145		106,075	230,220		230,220	(230,220)				43
44	**TOTAL Special Cost Centers**	163,671	299,844	667,517	1,131,032		1,131,032	(266,616)	864,416			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	9,090,840	1,284,291	7,531,974	17,907,105		17,907,105	(793,960)	17,113,145			45

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

Facility Name & ID Number St Patricks Residence # 0035006 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(965)	2		4
5	Telephone, TV & Radio in Resident Rooms	(19,062)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	9,256	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	(25,302)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(407,417)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(350,470)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (793,960)		$	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))**	$ (793,960)		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 Patricks Residence

ID# 0035006

Report Period Beginning: 01/01/2016

Ending: 12/31/2016

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Coffee/Gift Shop Expense	$ (36,396)	41	1
2	Investment Fees	(63,513)	21	2
3	Development Salaries	(124,145)	43	3
4	Fundraising/Special Events Expense	(106,075)	43	4
5	Continuing Education	(5,099)	24	5
6	Non-allowable Travel	(13,496)	25	6
7	Lobbying Fees	(1,746)	20	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**	(350,470)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number St Patricks Residence # 0035006 **Report Period Beginning:** 01/01/2016 **Ending:** 12/31/2016

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	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(965)	0	0	0	0	0	0	0	0	0	0	(965)	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	(19,062)	0	0	0	0	0	0	0	0	0	0	(19,062)	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**	(20,027)	0	0	0	0	0	0	0	0	0	0	(20,027)	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	(1,746)	0	0	0	0	0	0	0	0	0	0	(1,746)	20
21	Clerical & General Office Expenses	(496,232)	0	0	0	0	0	0	0	0	0	0	(496,232)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(5,099)	0	0	0	0	0	0	0	0	0	0	(5,099)	24
25	Other Admin. Staff Transportation	(13,496)	0	0	0	0	0	0	0	0	0	0	(13,496)	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**	(516,573)	0	0	0	0	0	0	0	0	0	0	(516,573)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(536,600)	0	0	0	0	0	0	0	0	0	0	(536,600)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number St Patricks Residence # 0035006 **Report Period Beginning:** 01/01/2016 **Ending:** 12/31/2016

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	9,256	0	0	0	0	0	0	0	0	0	0	9,256	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	9,256	0	0	0	0	0	0	0	0	0	0	9,256	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	(36,396)	0	0	0	0	0	0	0	0	0	0	(36,396)	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(230,220)	0	0	0	0	0	0	0	0	0	0	(230,220)	43
44	**TOTAL Special Cost Centers**	(266,616)	0	0	0	0	0	0	0	0	0	0	(266,616)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(793,960)	0	0	0	0	0	0	0	0	0	0	(793,960)	45

Facility Name & ID Number St Patricks Residence # 0035006 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	Administrative	$ 94,620	Carmelite System for the Aged and Inform, Inc.	100.00%	$ 94,620	$	1
2	V	17	Management Fees	158,868	Carmelite System for the Aged and Inform, Inc.	100.00%	158,868		2
3	V	12	Sister Compensation	39,336	Carmelite System for the Aged and Inform, Inc.	100.00%	39,336		3
4	V	21	Sister Compensation	21,936	Carmelite System for the Aged and Inform, Inc.	100.00%	21,936		4
5	V	10	Sister Compensation	20,955	Carmelite System for the Aged and Inform, Inc.	100.00%	20,955		5
6	V	22	Medical	30,645	Carmelite System for the Aged and Inform, Inc.	100.00%	30,645		6
7	V	22	Pension	3,538	Carmelite System for the Aged and Inform, Inc.	100.00%	3,538		7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 369,898			$ 369,898	$ *	14

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

Facility Name & ID Number St Patricks Residence # 0035006 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	Carmelite Sisters for the Aged and	100%	None		Carmelite Sisters	Germantown, NY	Religious Order	1
2	Inform, Inc.				for the Aged and Inform, Inc.			2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
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24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number St Patricks Residence # 0035006 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	Mr. Charles Millington	Chairman							$		1
2	Sister Mary Rose Heery	O.Carm.									2
3	Sister Patricia Margaret Rawd	O.Carm.									3
4	Sister Teresa Kennedy	O.Carm.									4
5	Sister Lois Joseph Baniewicz	O.Carm.									5
6	Sister Ann Elizabeth Brown	O.Carm.									6
7	Sister Alice Webster	O.Carm.									7
8	Sister M. Marcian Deisenroth	RSM									8
9	Mr. John J. Durso										9
10	Mr. William H. Hayes										10
11	Mr. Raymond E. Jones										11
12	Reverend James Lennon										12
13								TOTAL	$		13

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

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

Facility Name & ID Number St Patricks Residence # 0035006 Report Period Beginning: 01/01/2016 Ending: 2/31/2016

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	N/A					$	$		$	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 St Patricks Residence # 0035006 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	N/A						$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	N/A											6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

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

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

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

Facility Name & ID Number St Patricks Residence # 0035006 **Report Period Beginning:** 01/01/2016 **Ending:** 12/31/2016

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

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 Patricks Residence COUNTY DuPage

FACILITY IDPH LICENSE NUMBER 0035006

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 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 St Patricks Residence # 0035006 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? [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).

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	Facility	7.33 Acres	1987	$ 638,590	1
2					2
3	TOTALS	7.33 Acres		$ 638,590	3

Facility Name & ID Number St Patricks Residence # 0035006 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	210		1989	1989	$ 7,786,645	$	25-40	$ 115,433	$ 115,433	$ 6,382,057	4
5			1997	1997	2,194,676		40	54,867	54,867	1,069,905	5
6			2000	2000	2,987,034		40	74,675	74,675	1,213,461	6
7			2005	2005	894,078		35	12,939	12,939	280,690	7
8											8
	Improvement Type**										
9	1991 Improvements			1991	4,862		20			4,862	9
10	1993 Improvements			1993	6,175		20			6,175	10
11	1994 Improvements			1994	32,324		20			32,324	11
12	1996 Improvements			1996	2,976		20			2,976	12
13	1997 Improvements			1997	52,566		20	2,030	2,030	51,551	13
14	1998 Improvements			1998	28,215		20	514	514	20,043	14
15	1999 Improvements			1999	6,832		20			6,832	15
16	2000 Improvements			2000	16,581		20	829	829	13,536	16
17	2001 Improvements			2001	10,440		20	522	522	8,091	17
18	2002 Improvements			2002	3,966		20			3,966	18
19	2005 Improvements			2005	10,938		20			10,938	19
20	2006 Improvements			2006	226,358		20	13,495	13,495	187,172	20
21	2007 Improvements			2007	101,740		20	9,362	9,362	83,943	21
22	2008 Improvements			2008	250,909		20	13,557	13,557	124,497	22
23	Repair Coil On roof			2009	3,728		20	186	186	1,302	23
24	Front Entrance Sign			2009	5,288		20	176	176	1,232	24
25	Elevator Final Payment			2009	20,875		20	1,044	1,044	7,308	25
26	Repair 2 Roof Areas			2009	21,077		20	1,054	1,054	7,378	26
27	Firm Pump Repair			2009	3,402		20	170	170	1,190	27
28	Elevator Work			2009	2,500		20	63	63	441	28
29	Wander Prevention System			2009	6,963		20	348	348	2,436	29
30	SS Panels for Kitchen			2009	8,797		20	440	440	3,080	30
31	Replace Furnace New Addition			2009	6,134		20	307	307	2,149	31
32	42 Cornices			2009	6,005		20	300	300	2,100	32
33	Replace Txv Valve / Hallway AC			2009	2,835		20	142	142	994	33
34	Wander Prevention System			2009	8,484		20	424	424	2,968	34
35	Compressor			2009	4,117		20	206	206	1,442	35
36	Boiler			2009	4,031		20	202	202	1,305	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 Patricks Residence # 0035006 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	Walk-In-Cooler	2009	$ 19,874	$	20	$ 662	$ 662	$ 4,634	37
38	Door Kick Plates	2009	6,060		20	303	303	2,121	38
39	Parts for Walk-In Cooler	2010	5,463		20	273	273	1,638	39
40	Walk-In Cooler	2010	7,951		20	398	398	2,387	40
41	Front Door Roam Alert System	2010	2,559		20	128	128	768	41
42	Air Curtain - Employee Entrance	2010	4,900		20	245	245	1,470	42
43	Booster Water Heater / Blaster Chiller	2010	10,496		20	525	525	3,150	43
44	Backflow Preventer	2010	13,139		20	657	657	3,942	44
45	Sprinkler Heads in Elevator	2010	4,630		20	232	232	1,391	45
46	Roofing Repairs	2010	8,500		20	425	425	2,550	46
47	A/C Pipes & Valves	2010	6,054		20	303	303	1,817	47
48	Walk-In Cooler	2010	17,593		20	880	880	5,279	48
49	Landscaping	2010	4,500		20	225	225	1,350	49
50	Roof Top Garden / Patio	2010	7,645		20	382	382	1,910	50
51	Air Curtain	2011	4,650		20	233	233	1,165	51
52	Security System - Employee Entrance	2011	8,245		20	412	412	2,060	52
53	Lobby A/C	2011	2,846		20	142	142	710	53
54	Lobby Compressor	2011	5,160		20	258	258	1,290	54
55	Privacy Curtains / Cornices	2011	11,956		20	598	598	2,990	55
56	Security System - Employee Entrance	2011	8,284		20	414	414	2,070	56
57	Roof Top Garden / Patio	2011	2,500		20	125	125	625	57
58	Roof Top Garden / Patio	2011	49,072		20	2,454	2,454	12,270	58
59	Roof Top Garden / Patio	2011	61,692		20	3,085	3,085	15,425	59
60	Back Door	2011	3,800		20	190	190	950	60
61	Concrete - Compactor Base Pad	2011	2,850		20	143	143	715	61
62	Roof Replacement	2011	19,700		20	985	985	4,925	62
63	Amex/Wet - Glycol for Heating System	2012	2,573		20	129	129	516	63
64	Amex/Chemicals for A/C System	2012	2,578		20	129	129	516	64
65	Wm F. Meyer - Sewer Rodder - Amex	2012	2,620		20	131	131	524	65
66	Chase/Classic Fence - Fence for Compactor	2012	2,768		20	138	138	552	66
67	Robert Gill & Co. - Shelving	2012	2,904		20	145	145	580	67
68	Amex/Sun Ray Heating - Repair Boiler Coil	2012	2,950		20	148	148	592	68
69									69
70	TOTAL (lines 4 thru 69)		$ 15,038,063	$		$ 318,782	$ 318,782	$ 9,621,226	70

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

Facility Name & ID Number St Patricks Residence # 0035006 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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		$ 15,038,063	$		$ 318,782	$ 318,782	$ 9,621,226	1
2	Amex/Break Room Flooring	2012	3,507		20	175	175	700	2
3	RJKeck Piping/Install PVC	2012	4,609		20	230	230	920	3
4	Metro Tank and Pump Co/Instl 300 Gal Tank	2012	5,000		20	250	250	1,000	4
5	Accelerated Care Plus Corp - Omnicycle Rehab System	2012	6,096		20	305	305	1,220	5
6	Chase/Replace HVAC Unit	2012	6,305		20	315	315	1,260	6
7	Metro Tank - Diesel Fuel Tank	2012	10,869		20	543	543	2,172	7
8	Precision Cntrl/Chase - Piping & Valve System	2012	11,355		20	568	568	2,272	8
9	Amex/Neuco - HVAC Air Handler	2012	14,323		20	716	716	2,864	9
10	Chase/Great Lakes Paving - Blacktop Front & Convent	2012	18,765		20	938	938	3,752	10
11	Great Lakes Paving - Resurface Front Lot/Circle	2012	21,600		20	1,080	1,080	4,320	11
12	Showalter Roofing Service Inc - Roof Repairs	2012	22,710		20	1,136	1,136	4,544	12
13	Great Lakes Paving - Paving	2013	14,175		20	1,418	1,418	4,961	13
14	Amex/Showalter Roofing - Roof Repair	2013	3,720		10	372	372	1,302	14
15	Chase/Showalter Roofing - Partial Roof Replacement	2013	2,560		10	256	256	896	15
16	Jim Wagner Plumbing - 2 Copper Hot Water Supply	2013	3,394		10	339	339	1,188	16
17	Amex/West Side Mech - Fire Dampers	2013	4,200		10	420	420	1,470	17
18	Gilkerson Masonry - Tuckpoint Block Walls	2013	12,760		10	1,276	1,276	4,466	18
19	Lowery Tiel	2013	5,092		10	509	509	1,782	19
20	Chase/Thermo Heat Exchanger Cleaning system	2013	3,422		5	684	684	2,395	20
21	Clost Designs & More - Coffee Shop Cabinets	2013	2,600		10	260	260	910	21
22	Edot - Install Surveillance Cameras	2013	3,000		10	300	300	1,050	22
23	Edot - Parking Lot Cameras	2013	3,120		10	312	312	1,092	23
24	Amex/Century Tile - Coffee Shop Tile - Guild	2013	3,023		10	302	302	1,058	24
25	Roseland Draperies - 2E/2W Cornices/Shades	2013	7,377		10	738	738	2,582	25
26	Amex/H-Mac Gas Duct Furnace	2013	3,188		10	319	319	1,116	26
27	Amex/West USA Ethylene Glycol 4-55 gal	2013	2,889		10	289	289	1,011	27
28	Entegra Procurement Svcs - Air Curtain Refrigerator	2013	10,976		10	1,098	1,098	3,842	28
29	Ashland Door solutions	2014	11,627		20	581	581	1,453	29
30	Madden Glass/event room & 4 office Windows	2014	22,360		15	1,491	1,491	3,727	30
31	Madden Glass/ 16 Winvent screens	2014	1,317		15	88	88	220	31
32	Precision Piping for 1west heating/cooling	2014	2,950		15	494	494	1,234	32
33									33
34	TOTAL (lines 1 thru 33)		$ 15,286,952	$		$ 336,584	$ 336,584	$ 9,684,005	34

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

Facility Name & ID Number St Patricks Residence # 0035006 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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 12B, Carried Forward		$ 15,286,952	$		$ 336,584	$ 336,584	$ 9,684,005	1
2	Chapel Heat Exchanger	2014	10,250		15	683	683	1,708	2
3	Inpro Elevator Update	2015	8,259		10	826	826	1,239	3
4	Inpro Elevator Update	2015	6,246		10	625	625	937	4
5	Ashland Door solutions 1st half 2nd &3rd flo fire doors	2015	18,626		10	1,863	1,863	2,794	5
6	Ashland door solutions 2nd half 2nd&3rd flr fire doors	2015	21,371		20	1,069	1,069	1,603	6
7	Westside Mechanical	2015	5,116		15	341	341	512	7
8	Reliant Electrocal Electric for AC	2015	2,758		10	276	276	414	8
9	Gilkerson Masonary Convent outside repair	2015	11,410		10	1,141	1,141	1,712	9
10	Westside Mechanical Main Electric Room A/C	2015	18,950		15	1,263	1,263	1,895	10
11	Adler Plumbing & heating Inc/replace wite pipe/mixing valves	2015	15,320		20	766	766	1,149	11
12	Hufcor Doors - Chase Ink	2016	4,330		10	217	217	217	12
13	Chase Ink/Fire Panel	2016	3,500		15				13
14	Chase-Ink/Relock Utility rm Doors	2016	2,627		5	263	263	263	14
15	BTI 17 Camera additions	2016	9,691		5	969	969	969	15
16	State Mechanical Services elevator cooling unit	2016	22,975		20	574	574	574	16
17	Amex Crowthers Roofing	2016	3,940		30	66	66	66	17
18	Chase Ink AV Ovrhd Door	2016	3,550		30	60	60	60	18
19	Reliant electric Relocation Circuit emergency	2016	3,960		20	99	99	99	19
20	Amex Showalter Roofing (May & July)	2016	7,535		20	188	188	188	20
21	Nuyen industries Canope employee entrance	2016	8,250		20	206	206	206	21
22	Noland Sales Corp lobby & hall vinyl plank flooring	2016	27,809		20	695	695	695	22
23	NC Concrete Co. Asphalt replacement	2016	8,340		10	417	417	417	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)		$ 15,511,765	$		$ 349,191	$ 349,191	$ 9,701,722	34

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

Facility Name & ID Number St Patricks Residence # 0035006 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	$ 4,531,480	$	$ 202,185	$ 202,185		$ 3,772,711	71
72	Current Year Purchases	476,438		21,070	21,070		21,070	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 5,007,918	$	$ 223,255	$ 223,255		$ 3,793,781	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		2001 Dodge Grand Caravan	2004	$ 12,026	$	$	$	5	$ 12,026	76
77		2008 Chevy Bus	2007	49,512		4,951	4,951	10	45,385	77
78		2008 Silverado Pickup	2008	23,591		2,359	2,359	10	20,052	78
79		See Attached		14,913		1,492	1,492	10	10,280	79
80	TOTALS			$ 100,042	$	$ 8,802	$ 8,802		$ 87,743	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)	$ 21,258,315	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 581,248	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 581,248	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 13,583,246	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number St Patricks Residence # 0035006 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

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	$

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

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

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

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	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 Patricks Residence # 0035006 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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.

$

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 Patricks Residence STATE OF ILLINOIS # 0035006 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10-3	hrs	$		$ 116,031	$		$ 116,031	1
2	Licensed Speech and Language Development Therapist	10-3	hrs			115,199			115,199	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10-3	hrs			671,821			671,821	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				263,448		263,448	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): See Supplemental Sche	39-3					39,834		39,834	12
13	Other (specify):									13
14	TOTAL			$		$ 903,051	$ 303,282		$ 1,206,333	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 St Patricks Residence **#** 0035006 **Report Period Beginning:** 01/01/2016 **Ending:** 12/31/2016

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2016 **(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	$ 1,089,240	$	1
2	Cash-Patient Deposits	5,301		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 520,720)	1,818,240		3
4	Supply Inventory (priced at)	70,641		4
5	Short-Term Investments			5
6	Prepaid Insurance	33,299		6
7	Other Prepaid Expenses	20,419		7
8	Accounts Receivable (owners or related parties)	1,988		8
9	Other(specify): AR - Other	854,366		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,893,494	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	7,717,929		12
13	Land	638,590		13
14	Buildings, at Historical Cost	15,063,207		14
15	Leasehold Improvements, at Historical Cost	234,951		15
16	Equipment, at Historical Cost	5,604,617		16
17	Accumulated Depreciation (book methods)	(13,758,940)		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): CIP	439,130		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 15,939,484	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 19,832,978	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 827,070	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	5,301		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	506,166		30
31	Accrued Taxes Payable (excluding real estate taxes)	20,030		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	Due to related party	7,143		36
37	Other - see BS37	1,000,350		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,366,060	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,366,060	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 17,466,918	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 19,832,978	$	48

***(See instructions.)**

Facility Name & ID Number St Patricks Residence # 0035006 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 17,930,692	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 17,930,692	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(463,774)	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)**	$ (463,774)	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)**	$ 17,466,918	24 *

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

Facility Name & ID Number St Patricks Residence # 0035006 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	$ 17,329,087	1
2	Discounts and Allowances for all Levels	(3,724,882)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 13,604,205	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,833,706	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,833,706	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	61,030	12
13	Barber and Beauty Care	50,724	13
14	Non-Patient Meals	965	14
15	Telephone, Television and Radio	19,062	15
16	Rental of Facility Space	64,109	16
17	Sale of Drugs	236,538	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	59,817	19
20	Radiology and X-Ray	10,636	20
21	Other Medical Services	407,737	21
22	Laundry	211	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 910,829	23
	D. Non-Operating Revenue		
24	Contributions	663,999	24
25	Interest and Other Investment Income***	389,220	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,053,219	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	41,372	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 41,372	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 17,443,331	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	3,044,629	31
32	Health Care	9,053,476	32
33	General Administration	4,105,976	33
	B. Capital Expense		
34	Ownership	571,992	34
	C. Ancillary Expense		
35	Special Cost Centers	609,424	35
36	Provider Participation Fee	521,608	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 17,907,105	40
41	**Income before Income Taxes (line 30 minus line 40)****	(463,774)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (463,774)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 4,950,665	44
45	Private Pay - Net Inpatient Revenue	7,711,248	45
46	Medicare - Net Inpatient Revenue	679,109	46
47	Other-(specify) Insurance	253,035	47
48	Other-(specify) Managed Care	10,148	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 13,604,205	49

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

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

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

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

Facility Name & ID Number St Patricks Residence # 0035006 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	2,080	2,120	$ 105,258	$ 49.65	1
2	Assistant Director of Nursing	2,189	2,229	90,068	40.41	2
3	Registered Nurses	53,322	54,778	1,844,712	33.68	3
4	Licensed Practical Nurses	38,472	39,536	1,094,869	27.69	4
5	CNAs & Orderlies	147,638	151,614	2,295,036	15.14	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	10,474	10,754	195,902	18.22	8
9	Activity Director	2,080	2,120	52,063	24.56	9
10	Activity Assistants	20,288	20,848	270,706	12.98	10
11	Social Service Workers	9,779	10,059	202,574	20.14	11
12	Dietician	2,253	2,293	53,431	23.30	12
13	Food Service Supervisor	8,455	8,679	186,403	21.48	13
14	Head Cook	6,629	6,797	127,482	18.76	14
15	Cook Helpers/Assistants	44,629	46,253	492,371	10.65	15
16	Dishwashers	7,449	7,673	80,715	10.52	16
17	Maintenance Workers	14,958	15,238	300,823	19.74	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,080	2,120	105,566	49.80	20
21	Assistant Administrator			94,620		21
22	Other Administrative	30,924	27,924	766,756	27.46	22
23	Office Manager					23
24	Clerical	11,909	12,222	417,163	34.13	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: Nursing Support	15,185	15,498	314,322	20.28	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	430,792	438,754	$ 9,090,840 *	$ 20.72	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		$		35
36	Medical Director	120	33,366	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		16,414	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	34	2,347	10-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	154	$ 52,127		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	6,243	279,965	10-3	51
52	Certified Nurse Assistants/Aides	28,661	664,888		52
53	TOTAL (lines 50 - 52)	34,904	$ 944,853		53

Facility Name & ID Number St Patricks Residence # 0035006 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Marilyn Daley	Administrator	0	$ 105,566
Sr Anthony Veilleux	Asst Administrator	0	94,620
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 200,186

B. Administrative - Other

Description	Amount
Carmelite System Dues	$ 158,868
TOTAL (agree to Schedule V, line 17, col. 3)	$ 158,868
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Nixon Peaboy	Legal	$ 34,214
Poisinelli PC	Legal	2,273
CliftonLarsonAllen	Audit/Tax	23,400
Marcum LLP	Consulting	181
MRA The Management Association	HR Consulting	11,609
Pathway Health Service	Consulting	999
Medicare Cnsltng C/R	Consulting	3,000
Outsource Solutions Group	Support	4,400
Practical System Solutions	Consulting	8,688
Health Pro	Consulting	520
Paylocity	Payroll	20,434
Total from PG21 Supp		7,805
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 117,523

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 168,581
Unemployment Compensation Insurance	18,550
FICA Taxes	653,334
Employee Health Insurance	1,021,690
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension	105,542
Life & Disability	61,227
Staff Development	2,967
TOTAL (agree to Schedule V, line 22, col.8)	$ 2,031,891

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 2,150
Advertising: Employee Recruitment	25,226
Health Care Worker Background Check	262
(Indicate # of checks performed 10)	
Patient Background Checks 11	110
Dues/Subscriptions/License	63,626
Less: Public Relations Expense	(1,746)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 89,628

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 13,496
In-State Travel	
Seminar Expense	5,099
Non-allowable adjustment Pg. 5A	(18,595)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

**See instructions.

C. Professional Services

Vendor/Payee	Type	Amount
Information Controls	Consulting	6,155
Chase Card Services	CC fees	155
Everbank	Xerox rental	465
AMEX	CC fees	1,030
To PG21, Sect. C		7,805

Facility Name & ID Number St Patricks Residence # 0035006 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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? **YES**
If YES, give association name and amount. **Leading Age $4,849**

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

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **74,361** Line **10**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **521,608**
This amount is to be recorded on line 42 of Schedule V.

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

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

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **YES** Indicate the amount. $ **750**

(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? **YES**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **YES**
Firm Name: **CliftonLarsonAllen LLP**

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

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