FOR BHF USE

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2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

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: Larry Templin **Telephone Number:** (630) 361-2868
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 7/1/16 to 6/30/17 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) Tim Wiley
(Title) Administrator

Paid Preparer

(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title) Larry Templin, Partner
(Firm Name & Address) Templin Healthcare Accounting Services, LLP, P.O. Box 9, Dunlap, IL 61525
(Telephone) (630) 361-2868 Fax # ( )

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number St Joseph Nursing Home # 0005637 Report Period Beginning: 7/1/16 Ending: 6/30/17

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 N/A

	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	33,945	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	33,945	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	1,876	2,944	2,147	6,967	8
9	SNF/PED					9
10	ICF	12,195	7,923		20,118	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,071	10,867	2,147	27,085	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.79%

D. How many bed reserve days during this year were paid by the Department?
0 (Do not include bed reserve 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] Non-allowable costs have been eliminated in Schedule V, Column 7

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 1,857

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number St Joseph Nursing Home # 0005637 Report Period Beginning: 7/1/16 Ending: 6/30/17

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	260,577	15,915	7,474	283,966		283,966		283,966			1
2	Food Purchase		220,003		220,003		220,003	(54,854)	165,149			2
3	Housekeeping	75,216	19,584		94,800		94,800		94,800			3
4	Laundry	61,897	5,363		67,260		67,260		67,260			4
5	Heat and Other Utilities			112,815	112,815		112,815	(4,171)	108,644			5
6	Maintenance	72,524	16,650	23,872	113,046		113,046		113,046			6
7	Other (specify):*											7
8	TOTAL General Services	470,214	277,515	144,161	891,890		891,890	(59,025)	832,865			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,816,375	89,416	48,863	1,954,654		1,954,654		1,954,654			10
10a	Therapy											10a
11	Activities	102,901	901	3,130	106,932		106,932		106,932			11
12	Social Services	45,568	234	2,280	48,082		48,082		48,082			12
13	CNA Training											13
14	Program Transportation			3,297	3,297		3,297		3,297			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,964,844	90,551	57,570	2,112,965		2,112,965		2,112,965			16
	C. General Administration											
17	Administrative	102,647		249,044	351,691		351,691		351,691			17
18	Directors Fees											18
19	Professional Services			94,045	94,045		94,045		94,045			19
20	Dues, Fees, Subscriptions & Promotions			32,856	32,856		32,856		32,856			20
21	Clerical & General Office Expenses	96,834	15,762	13,078	125,674		125,674	(3,337)	122,337			21
22	Employee Benefits & Payroll Taxes			582,110	582,110		582,110		582,110			22
23	Inservice Training & Education			540	540		540		540			23
24	Travel and Seminar			325	325		325		325			24
25	Other Admin. Staff Transportation			3,317	3,317		3,317		3,317			25
26	Insurance-Prop.Liab.Malpractice			48,014	48,014		48,014		48,014			26
27	Other (specify):*											27
28	TOTAL General Administration	199,481	15,762	1,023,329	1,238,572		1,238,572	(3,337)	1,235,235			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,634,539	383,828	1,225,060	4,243,427		4,243,427	(62,362)	4,181,065			29

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

SEE ACCOUNTANTS' PREPARATION REPORT

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: 7/1/16 Ending: 6/30/17

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			49,392	49,392		49,392		49,392			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			22,576	22,576		22,576	(8,115)	14,461			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			71,968	71,968		71,968	(8,115)	63,853			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			1,998	1,998		1,998		1,998			38
39	Ancillary Service Centers		114,558	298,845	413,403		413,403		413,403			39
40	Barber and Beauty Shops			18,418	18,418		18,418		18,418			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			224,009	224,009		224,009		224,009			42
43	Other (specify):* Disallowed Costs	37,584		349,826	387,410		387,410	(387,410)				43
44	TOTAL Special Cost Centers	37,584	114,558	893,096	1,045,238		1,045,238	(387,410)	657,828			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,672,123	498,386	2,190,124	5,360,633		5,360,633	(457,887)	4,902,746			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number St Joseph Nursing Home # 0005637 Report Period Beginning: 7/1/16 Ending: 6/30/17

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	(54,854)	2		4
5	Telephone, TV & Radio in Resident Rooms	(11,901)	43		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	(5,140)	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				17
18	Fines and Penalties	(13,085)	43		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	(314,351)	43		24
25	Fund Raising, Advertising and Promotional	(10,489)	43		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 See Page 5A	(48,067)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (457,887)		$	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))**	$ (457,887)		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.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' PREPARATION REPORT

St Joseph Nursing Home

ID# 0005637

Report Period Beginning: 7/1/16

Ending: 6/30/17

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Sisters' Portion of Heat and Other Utilities	$ (4,171)	5	1
2	Offset Miscellaneous Income Against Office Supplies	(3,337)	21	2
3	Disallow Related Party Interest Expense	(2,975)	32	3
4	Disallow Marketing Wages	(37,584)	43	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
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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**	(48,067)		49

Facility Name & ID Number St Joseph Nursing Home # 0005637 Report Period Beginning: 7/1/16 Ending: 6/30/17

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		None		None		

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 [X] 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.**

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number St Joseph Nursing Home # 0005637 Report Period Beginning: 7/1/16 Ending: 6/30/17

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	Board of Directors							1
2	Sister Loretta Matas-President	0						2
3	Sister Michael Fox-Sec/Treasurer	0						3
4	Sister Miroslava Gelatikova	0						4
5	Sister Justina Delonga	0						5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
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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: 7/1/16 Ending: 6/30/17

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Sister Michael Fox	Secretary/Treasurer	Administrative	0.00	None	1	4.35	N/A	$ None	N/A	1
2	Sister Miroslava Gelatikova	Board Member	Administrative	0.00	None	1	3.14	N/A	None	N/A	2
3	Sister Michael Fox	C.N.A	Nursing	0.00	None	22	95.65	Wages	32,074	L10,C1	3
4	Sister Miroslava Gelatikova	Activities Associate	Activities	0.00	None	31	96.86	Wages	14,239	L11,C1	4
5											5
6											6
7											7
8											8
9	Both Sisters listed above are employees of the facility as well as Board members.										9
10											10
11											11
12											12
13								TOTAL	$ 46,313		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: 7/1/16 Ending: 6/30/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number St Joseph Nursing Home # 0005637 Report Period Beginning: 7/1/16 Ending: 6/30/17

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	1st National Bank of Lacon		X	Working Capital	$5,000.00	11/14/16	$ 400,000	$ 324,354	10/14/23	0.0475	$ 14,461	1
2	Sisters of St Francis of Assisi	X		Working Capital	Interest Only	9/1/16	791,000	791,000	09/01/23	1.2500	8,115	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$5,000.00		$ 1,191,000	$ 1,115,354			$ 22,576	9
	B. Non-Facility Related*											
10												10
11						Offset Interest Income					(5,140)	11
12						Disallow Remainder of Related Party Interest					(2,975)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (8,115)	14
15	TOTALS (line 9+line14)						$ 1,191,000	$ 1,115,354			$ 14,461	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None Line # N/A

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

SEE ACCOUNTANTS' PREPARATION REPORT

** 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:** 7/1/16 **Ending:** 6/30/17

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 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.)	**2016**	$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2017 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:			
	2012		**8**
	2013		**9**
	2014		**10**
	2015		**11**
	2016		**12**

This Worksheet is Not Applicable

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2016	$	**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.

2016 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 Tim Wiley

TELEPHONE (309) 246-2175 FAX #: (309) 246-2299

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

Enter the tax index number and real estate tax assessed for 2016 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 2016.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	This Worksheet is Not Applicable		$	$
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 X 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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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: 7/1/16 Ending: 6/30/17

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 66,656 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

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).

None

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

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred:

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	Patient Care	428,532	1965	$ 25,700	1
2					2
3	TOTALS	428,532		$ 25,700	3

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number St Joseph Nursing Home # 0005637 Report Period Beginning: 7/1/16 Ending: 6/30/17

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	1965	$ 465,065	$	50	$	$	$ 465,065	4
5	50		1969	1969	898,293	17,966	50	17,966		844,395	5
6			1968	1968	395,224		25			395,224	6
7			1986	1986	9,717		12			9,717	7
8			2010	2010	5,818	388	15	388		3,103	8
	Improvement Type**										
9	Misc			1968	6,160	123	50	123		6,036	9
10	Garage			1972	2,491	50	50	50		2,242	10
11	Finish Basement			1973	6,343	127	50	127		5,582	11
12	Window			1974	900	18	50	18		774	12
13	Insulation			1976	21,986	440	50	440		18,029	13
14	Roof			1980	16,049	321	50	321		11,876	14
15	Misc Remodeling			1981	7,711		10			7,711	15
16	IDPA Audit Adjustment			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 Repairs			1993	434		10			434	23
24	Water Heater			1993	223		15			223	24
25	Boiler Repair			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		89	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 Repair			2002	2,900		8			2,900	34
35	75 Gallon 365M ASME Water Heater			2006	5,225	259	10	259		5,225	35
36	ULTRA CARE 709 BED LAMINATE PANELS			2006	5,809	387	15	387		4,064	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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number St Joseph Nursing Home # 0005637 Report Period Beginning: 7/1/16 Ending: 6/30/17

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	$ 151	10	$ 151	$	$ 3,020	37
38	Hoyer Prof Vertical Patient Lift w/Scale	2006	4,249	216	10	216		4,249	38
39	Concrete Sidewalk	2007	5,220	348	15	348		3,306	39
40	Roofing	2007	20,986	2,099	10	2,099		19,935	40
41	Fire Dampers	2007	13,100	873	15	873		8,298	41
42	Beds (16)	2007	19,904	1,327	15	1,327		12,610	42
43	Door Alarm System	2007	20,963	1,398	15	1,398		13,279	43
44	EQUIPMENT - NURSING SERVICE	2008	21,360	1,424	15	1,424		10,899	44
45	KITCHEN SUPPRESSION HOOD	2010	3,321		5			3,321	45
46	MODIFY GAS PIPING TO KITCHEN	2010	1,585		5			1,585	46
47	AIR CONDITIONING UNIT	2011	45,717	2,286	20	2,286		16,001	47
48	MEDICAL EQUIPMENT -DEFIBRILATOR	2011	1,562	156	10	156		1,093	48
49	LOUNGE REMODEL: WALL REPAID AND PAINT	2012	1,100	110	10	110		660	49
50	LOUNGE REMODEL: FLOORING (CARPETING) INSTALL	2012	3,465	173	20	173		1,039	50
51	REHAB ROOM UPGRADE: PAINT, VINLY FLOOR & PURCH	2012	4,344	434	10	434		2,605	51
52	WATER HEATER AND BOOSTER	2012	4,817	241	20	241		1,446	52
53	DINING ROOM LIGHTS	2013	1,137	114	10	114		569	53
54	DINING ROOM DOOR	2013	7,445	745	10	745		3,413	54
55	LAND IMPROVEMENTS - EARTHWORK, PLANTS, MOBILA	2013	7,510	751	10	751		3,067	55
56	ADJUSTMENT FOR PY DEPRECIATION							31,446	56
57	Chapel Flooring and Painting	2014	19,580	783	25	783		3,002	57
58	Synthetic Wall Guard-Whole Facility (Lower Wall Covering)	2014	36,550	1,462	25	1,462		5,726	58
59	Concrete Flooring-External-Memorial Garden Patio	2014	35,808	2,387	15	2,387		9,349	59
60	Garage Roof Replacement	2015	1,250	125	10	125		260	60
61	Ice Machine Compressor Replacement	2015	650	130	5	130		271	61
62	WATER HEATER	2016	7,656	1,531	5	1,531		1,914	62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,669,363	$ 39,348		$ 39,348	$	$ 2,471,661	70

SEE ACCOUNTANTS' PREPARATION REPORT

**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: 7/1/16 Ending: 6/30/17

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	$		$ 207,343	71
72	Current Year Purchases	3,142	314	314			314	72
73	Fully Depreciated Assets	488,139					488,139	73
74								74
75	TOTALS	$ 808,423	$ 10,044	$ 10,044	$		$ 695,796	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	Chevy Caprice & Pick Up	1987	$ 24,879	$	$	$		$ 24,879	76
77	Nursing Home	Misc Other	VARIOUS	9,476					9,476	77
78	Nursing Home	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)	$ 3,584,707	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 49,392	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 49,392	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)	$ 3,248,678	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: 7/1/16 Ending: 6/30/17

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.	/2018	$
13.	/2019	$
14.	/2020	$

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: $ None Description: N/A
(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.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number St Joseph Nursing Home # 0005637 Report Period Beginning: 7/1/16 Ending: 6/30/17

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.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number St Joseph Nursing Home # 0005637 Report Period Beginning: 7/1/16 Ending: 6/30/17

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	39(3)	hrs	$	1,807	$ 129,933	$	1,807	$ 129,933	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		80	6,485		80	6,485	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(2), (3)	hrs		2,112	150,382		2,112	150,382	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				104,923		104,923	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Oxygen						9,635		9,635	12
13	Other (specify): Lab/X-Ray	39(3)				12,045			12,045	13
14	TOTAL			$	3,999	$ 298,845	$ 114,558	3,999	$ 413,403	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.

SEE ACCOUNTANTS' PREPARATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number St Joseph Nursing Home # 0005637 Report Period Beginning: 7/1/16 Ending: 6/30/17

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 6/30/17 (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	$ 457,631	$ 457,631	1
2	Cash-Patient Deposits	8,341	8,341	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 420,000)	643,283	643,283	3
4	Supply Inventory (priced at Cost)	15,426	15,426	4
5	Short-Term Investments			5
6	Prepaid Insurance	20,472	20,472	6
7	Other Prepaid Expenses	2,689	2,689	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,147,842	$ 1,147,842	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		25,700	13
14	Buildings, at Historical Cost	1,542,375	1,774,117	14
15	Leasehold Improvements, at Historical Cost	1,111,305	895,246	15
16	Equipment, at Historical Cost	905,092	889,644	16
17	Accumulated Depreciation (book methods)	(3,248,866)	(3,248,678)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	61,777	61,777	21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 371,683	$ 397,806	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,519,525	$ 1,545,648	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 347,924	$ 347,924	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	8,341	8,341	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	146,499	146,499	30
31	Accrued Taxes Payable (excluding real estate taxes)	30,865	30,865	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses	31,852	31,852	36
37	Overpayments	42,439	42,439	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 607,920	$ 607,920	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,115,354	1,115,354	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,115,354	$ 1,115,354	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,723,274	$ 1,723,274	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (203,749)	$ (177,626)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,519,525	$ 1,545,648	48

SEE ACCOUNTANTS' PREPARATION REPORT

***(See instructions.)**

Facility Name & ID Number St Joseph Nursing Home # 0005637 Report Period Beginning: 7/1/16 Ending: 6/30/17

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (76,385)	1
2	Restatements (describe):		2
3	**Rounding**	1	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (76,384)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(127,365)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (127,365)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (203,749)	24 *

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number St Joseph Nursing Home # 0005637 Report Period Beginning: 7/1/16 Ending: 6/30/17

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	$ 6,034,562	1
2	Discounts and Allowances for all Levels	(1,141,417)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,893,145	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	172,262	6
7	Oxygen	3,118	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 175,380	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	1,469	12
13	Barber and Beauty Care	16,051	13
14	Non-Patient Meals	54,854	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	7,689	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	51,875	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 131,938	23
	D. Non-Operating Revenue		
24	Contributions	24,328	24
25	Interest and Other Investment Income***	5,140	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 29,468	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellanous Income	3,337	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 3,337	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,233,268	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	891,890	31
32	Health Care	2,112,965	32
33	General Administration	1,238,572	33
	B. Capital Expense		
34	Ownership	71,968	34
	C. Ancillary Expense		
35	Special Cost Centers	821,229	35
36	Provider Participation Fee	224,009	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,360,633	40
41	**Income before Income Taxes (line 30 minus line 40)****	(127,365)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (127,365)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,733,627	44
45	Private Pay - Net Inpatient Revenue	2,222,435	45
46	Medicare - Net Inpatient Revenue	820,977	46
47	Other-(specify) Managed Care	116,106	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,893,145	49

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

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number St Joseph Nursing Home # 0005637 Report Period Beginning: 7/1/16 Ending: 6/30/17

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	2,115	2,351	$ 62,208	$ 26.46	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,633	6,210	174,089	28.03	3
4	Licensed Practical Nurses	24,424	26,028	610,914	23.47	4
5	CNAs & Orderlies	59,450	63,889	893,651	13.99	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,830	2,080	36,504	17.55	9
10	Activity Assistants	5,155	5,817	66,397	11.41	10
11	Social Service Workers	1,908	2,056	45,568	22.16	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	24,287	26,575	260,577	9.81	15
16	Dishwashers					16
17	Maintenance Workers	3,012	3,260	72,524	22.25	17
18	Housekeepers	7,644	8,381	75,216	8.97	18
19	Laundry	6,011	6,501	61,897	9.52	19
20	Administrator	2,016	2,182	102,647	47.04	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,381	8,029	96,834	12.06	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	1,790	2,086	20,675	9.91	31
32	Other Health Care(specify)					32
33	Other(specify) See Sch 20A	3,807	4,047	92,422	22.84	33
34	TOTAL (lines 1 - 33)	156,463	169,492	$ 2,672,123 *	$ 15.77	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	192	$ 7,474	L1, C3	35
36	Medical Director				36
37	Medical Records Consultant	23	1,786	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	894	6,371	L10, C3	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	2,280	L12, C3	45
46	Other(specify) Physician	4	350	L10, C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,142	$ 18,261		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	57	$ 2,304	L10, C3	50
51	Licensed Practical Nurses	959	32,839	L10, C3	51
52	Certified Nurse Assistants/Aides	167	5,137	L10, C3	52
53	TOTAL (lines 50 - 52)	1,183	$ 40,280		53

SEE ACCOUNTANTS' PREPARATION REPORT

St Joseph Nursing Home

Period Beginning **7/1/16**
Period End **6/30/17**

Schedule 20A

XVIII. Staffing and Salary Costs

		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
MDS Coordinator		1,827	1,959	54,838	27.99
Marketing		1,980	2,088	37,584	18.00
	TOTAL	3,807	4,047	92,422	

Facility Name & ID Number St Joseph Nursing Home # 0005637 Report Period Beginning: 7/1/16 Ending: 6/30/17

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jerlene Jamison	Administrator	0	$ 6,871
Tim Wiley	Administrator	0	95,776
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 102,647

B. Administrative - Other

Description	Amount
Franciscan Advisory Services	$ 249,044
TOTAL (agree to Schedule V, line 17, col. 3)	$ 249,044
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Brown Smith Wallace	Accounting	$ 30,575
Point Click Care	Accounting Software	26,484
Facet	Computer Support	8,478
Walker Phillips	Accounting	4,800
Galaxy	Payroll system	2,607
Ability	Medicare Billing / eligibility	7,204
Alliance	401K Administration	2,485
Kronos	Payroll timekeeping system	3,013
Nixon Peabody	Legal	3,664
Daniel Maher	Legal	920
Buchalter Nemer	Legal	1,905
Heyl Royster	Legal	1,910
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 94,045

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 55,986
Unemployment Compensation Insurance	54,706
FICA Taxes	189,781
Employee Health Insurance	258,552
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Incentives	1,850
Employee Physicals	16,148
Life Insurance	5,087
TOTAL (agree to Schedule V, line 22, col.8)	$ 582,110

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

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 3,980
Advertising: Employee Recruitment	25,911
Health Care Worker Background Check	
(Indicate # of checks performed 76)	760
Patient Background Checks 61	610
Miscellaneous Licenses and Fees	715
Miscellaneous Dues	880
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 32,856

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	325
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 325

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number St Joseph Nursing Home # 0005637 Report Period Beginning: 7/1/16 Ending: 6/30/17

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **N/A**

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

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **26,921** 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. $ **224,009**
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.

SEE ACCOUNTANTS' PREPARATION REPORT

(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. $ **54,854**

(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? **50**
d. Have vehicle usage logs been maintained? **No**
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: **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? **Yes**
See page 39 of the instructions for details.
Attach invoices and a summary of services for all architect and appraisal fees