FOR BHF USE

LL1

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.

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

I. IDPH License ID Number: 0035006

Facility Name: St. Patrick's Residence

Address: 1400 Brookdale Raod (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 01/01/2017 to 12/31/2017 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) Sr. Anthony Veilleux
(Title)

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. Patrick's Residence # 0035006 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	75,190	1
2		Skilled Pediatric (SNF/PED)			2
3	3	Intermediate (ICF)	3	1,095	3
4		Intermediate/DD			4
5	1	Sheltered Care (SC)	1	365	5
6		ICF/DD 16 or Less			6
7	210	TOTALS	210	76,650	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	31,560	24,226	4,716	60,502	8
9	SNF/PED					9
10	ICF		993		993	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	31,560	25,219	4,716	61,495	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.23%

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)
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 4,716

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2017 Fiscal Year: _____

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

Facility Name & ID Number St. Patrick's Residence # 0035006 **Report Period Beginning:** 01/01/2017 **Ending:** 12/31/2017

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	947,004	55,385	24,927	1,027,316		1,027,316		1,027,316			1
2	Food Purchase		488,271		488,271		488,271	(5,154)	483,117			2
3	Housekeeping			783,771	783,771		783,771		783,771			3
4	Laundry		1,780		1,780		1,780		1,780			4
5	Heat and Other Utilities			353,841	353,841		353,841	(13,075)	340,766			5
6	Maintenance	317,902		111,968	429,870		429,870		429,870			6
7	Other (specify):*											7
8	**TOTAL General Services**	1,264,906	545,436	1,274,507	3,084,849		3,084,849	(18,229)	3,066,620			8
	B. Health Care and Programs											
9	Medical Director			2,333	2,333		2,333		2,333			9
10	Nursing and Medical Records	5,796,727	257,601	645,031	6,699,359		6,699,359		6,699,359			10
10a	Therapy	130,172		729,349	859,521		859,521		859,521			10a
11	Activities	302,538	16,718	17,773	337,029		337,029		337,029			11
12	Social Services	171,070	8,801	10,768	190,639		190,639		190,639			12
13	CNA Training											13
14	Program Transportation			276	276		276		276			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	6,400,507	283,120	1,405,530	8,089,157		8,089,157		8,089,157			16
	C. General Administration											
17	Administrative	197,234		170,601	367,835		367,835		367,835			17
18	Directors Fees											18
19	Professional Services			94,664	94,664		94,664		94,664			19
20	Dues, Fees, Subscriptions & Promotions			143,957	143,957		143,957	(35,258)	108,699			20
21	Clerical & General Office Expenses	756,387	65,038	616,765	1,438,190		1,438,190	(320,586)	1,117,604			21
22	Employee Benefits & Payroll Taxes			2,073,288	2,073,288		2,073,288		2,073,288			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,640	2,640		2,640	(2,640)				24
25	Other Admin. Staff Transportation			14,650	14,650		14,650	(14,650)				25
26	Insurance-Prop.Liab.Malpractice			206,025	206,025		206,025		206,025			26
27	Other (specify):*											27
28	**TOTAL General Administration**	953,621	65,038	3,322,590	4,341,249		4,341,249	(373,134)	3,968,115			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	8,619,034	893,594	6,002,627	15,515,255		15,515,255	(391,363)	15,123,892			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. Patrick's Residence #0035006 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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			589,920	589,920		589,920		589,920			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			4,711	4,711		4,711	(4,711)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			3,212	3,212		3,212		3,212			35
36	Other (specify):*											36
37	**TOTAL Ownership**			597,843	597,843		597,843	(4,711)	593,132			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		290,470	162,499	452,969		452,969		452,969			39
40	Barber and Beauty Shops	25,122			25,122		25,122		25,122			40
41	Coffee and Gift Shops		22,659		22,659		22,659	(22,659)				41
42	Provider Participation Fee			466,778	466,778		466,778		466,778			42
43	Other (specify):*	135,825		89,553	225,378		225,378	(225,378)				43
44	**TOTAL Special Cost Centers**	160,947	313,129	718,830	1,192,906		1,192,906	(248,037)	944,869			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	8,779,981	1,206,723	7,319,300	17,306,004		17,306,004	(644,111)	16,661,893			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. Patrick's Residence # 0035006 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	(5,154)	2		4
5	Telephone, TV & Radio in Resident Rooms	(13,075)	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
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	(59,737)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(4,711)	32		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	(14,546)	21		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	(177,862)	21		24
25	Fund Raising, Advertising and Promotional	(29,010)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(340,016)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (644,111)		$	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))**	$ (644,111)		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. Patrick's Residence

ID# 0035006

Report Period Beginning: 01/01/2017

Ending: 12/31/2017

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Coffee/Gift Shop Expense	$ (22,659)	41	1
2	Investment Fees	(68,441)	21	2
3	Development Salaries	(135,825)	43	3
4	Fundraising/Special Events Expense	(89,553)	43	4
5	Continuing Education	(2,640)	24	5
6	Non-allowable Travel	(14,650)	25	6
7	Lobbying Fees	(6,248)	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**	(340,016)		49

Facility Name & ID Number St. Patrick's Residence # 0035006 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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. ☐ 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	Management Fees	$ 170,601		100.00%	$ 170,601	$	1
2	V	10	Sister Compensation	33,999		100.00%	33,999		2
3	V	12	Sister Compensation	38,461		100.00%	38,461		3
4	V	21	Sister Compensation	96,165		100.00%	96,165		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			$ 339,226			$ 339,226	$ *	14

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

Facility Name & ID Number St. Patrick's Residence # 0035006 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	Infirm, Inc.				for the Aged and Infirm, 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
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number St. Patrick's Residence # 0035006 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	Sr. M. Teresa Kathleen Domin	O.Carm.							$		1
2	Daniel Short, MD	Director									2
3	Sr. Mary Rose Heery	President									3
4	Sr. Patricia Rawdon	Vice President									4
5	John Durso	Secretary									5
6	Marilyn Daley	Treasurer									6
7	Mr. William H. Hayes	Chair									7
8	Mr. Charles Millington	Director									8
9	Sr. Alice Webster	O.Carm.									9
10	Ted Sidlow	Director									10
11											11
12											12
13								TOTAL	$		13

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

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

Facility Name & ID Number St. Patrick's Residence # 0035006 Report Period Beginning: 01/01/2017 Ending: 2/31/2017

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. Patrick's Residence # 0035006 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	N/A						$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6			X	WORKING CAPITAL			800,000	800,000			4,711	6
7												7
8												8
9	TOTAL Facility Related						$ 800,000	$ 800,000			$ 4,711	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 800,000	$ 800,000			$ 4,711	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. Patrick's Residence # 0035006 **Report Period Beginning:** 01/01/2017 **Ending:** 12/31/2017

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.)		$	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

	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. Patrick's 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 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.			$	$
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 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. Patrick's Residence # 0035006 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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. Patrick's Residence # 0035006 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	$		$	$	$	4
5			1997	1997	2,194,676						5
6			2000	2000	2,987,034						6
7			2005	2005	894,078						7
8											8
	Improvement Type**										
9	1991 Fixed Assets			1991	4,862						9
10	1993 Fixed Assets			1993	6,175						10
11	1994 Fixed Assets			1994	32,324						11
12	1996 Fixed Assets			1996	2,976						12
13	1997 Fixed Assets			1997	52,566						13
14	1998 Fixed Assets			1998	28,215						14
15	1999 Fixed Assets			1999	6,832						15
16	2000 Fixed Assets			2000	16,581						16
17	2001 Fixed Assets			2001	10,440						17
18	2002 Fixed Assets			2002	3,966						18
19	2005 Fixed Assets			2005	10,938						19
20	2006 Fixed Assets			2006	226,358						20
21	2007 Fixed Assets			2007	101,740						21
22	2008 Fixed Assets			2008	250,909						22
23	2009 Fixed Assets			2009	130,170						23
24	2010 Fixed Assets			2010	93,430						24
25	2011 Fixed Assets			2011	180,755						25
26	2012 Fixed Assets			2012	141,532						26
27	Great Lakes Paving - Paving			2013	14,175						27
28	Amex/Showalter Roofing - Roof Repair			2013	3,720						28
29	Chase/Showalter Roofing - Partial Roof Replacement			2013	2,560						29
30	Jim Wagner Plumbing - 2 Copper Hot Water Supply			2013	3,394						30
31	Amex/West Side Mech - Fire Dampers			2013	4,200						31
32	Gilkerson Masonry - Tuckpoint Block Walls			2013	12,760						32
33	Lowery Tiel			2013	5,092						33
34	Chase/Thermo Heat Exchanger Cleaning system			2013	3,422						34
35	Clost Designs & More - Coffee Shop Cabinets			2013	2,600						35
36	Edot - Install Surveillance Cameras			2013	3,000						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. Patrick's Residence # 0035006 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	Edot - Parking Lot Cameras	2013	$ 3,120	$		$	$	$	37
38	Amex/Century Tile - Coffee Shop Tile - Guild	2013	3,023						38
39	Roseland Draperies - 2E/2W Cornices/Shades	2013	7,377						39
40	Amex/H-Mac Gas Duct Furnace	2013	3,188						40
41	Amex/West USA Ethylene Glycol 4-55 gal	2013	2,889						41
42	Entegra Procurement Svcs - Air Curtain Refrigerator	2013	10,976						42
43	Ashland Door solutions	2014	11,627						43
44	Madden Glass/event room & 4 office Windows	2014	22,360						44
45	Madden Glass/ 16 Winvent screens	2014	1,317						45
46	Precision Piping for 1west heating/cooling	2014	2,950						46
47	Chapel Heat Exchanger	2014	10,250						47
48	Inpro Elevator Update	2015	8,259						48
49	Inpro Elevator Update	2015	6,246						49
50	Ashland Door solutions 1st half 2nd &3rd flo fire doors	2015	18,626						50
51	Ashland door solutions 2nd half 2nd&3rd flr fire doors	2015	21,371						51
52	Westside Mechanical	2015	5,116						52
53	Reliant Electrocal Electric for AC	2015	2,758						53
54	Gilkerson Masonary Convent outside repair	2015	11,410						54
55	Westside Mechanical Main Electric Room A/C	2015	18,950						55
56	Adler Plumbing & heating Inc/replace wite pipe/mixing valves	2015	15,320						56
57	Hufcor Doors - Chase Ink	2016	4,330						57
58	Chase Ink/Fire Panel	2016	3,500						58
59	Chase-Ink/Relock Utility rm Doors	2016	2,627						59
60	BTI 17 Camera additions	2016	9,691						60
61	State Mechanical Services elevator cooling unit	2016	22,975						61
62	Amex Crowthers Roofing	2016	3,940						62
63	Chase Ink AV Ovrhd Door	2016	3,550						63
64	Reliant electric Relocation Circuit emergency	2016	3,960						64
65	Amex Showalter Roofing (May & July)	2016	7,535						65
66	Nuyen industries Canope employee entrance	2016	8,250						66
67	Noland Sales Corp lobby & hall vinyl plank flooring	2016	27,809						67
68	NC Concrete Co. Asphalt replacement	2016	8,340						68
69	Ashland Door - Main Diningroom Doors	2017	603						69
70	TOTAL (lines 4 thru 69)		$ 15,512,368	$		$	$	$	70

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

Facility Name & ID Number St. Patrick's Residence # 0035006 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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		$ 15,512,368	$		$	$	$	1
2	Ashland Door - Bring maintenance doors up to code	2017	1,220						2
3	Ashowalter Roofing Services - Convent Roof	2017	1,199						3
4	Key Construction - Replace holding tanks	2017	6,112						4
5	Chase Card - Replacement pump for fire system	2017	685						5
6	Rogers Pump & Sales - Fire pump rebuild	2017	2,903						6
7	Gilkerson Masonry Corp - Reseal Convent Masonry	2017	4,400						7
8	Preferred Window and Door - Upgrade sliding doors	2017	6,200						8
9	TR from CIP - Cubicle Curtains	2017	2,487						9
10	PH PH Roofing down payment	2017	89,533						10
11	PH Deposit - Replace Patio Door	2017	3,213						11
12	Perkins Eastman Architects (shower remodel)	2017	17,873						12
13	City of Naperville (shower remodel)	2017	2,227						13
14	Mazur & Son Construction - shower remodel - see row 15								14
15	(General construction/demolition/drywall/ceramic tile all units)	2017	349,259						15
16	FSES Survey	2017	3,750						16
17	Perkins Eastman Architects	2017	44,198						17
18	State of Illinois	2017	6,336						18
19	IDPH Plan Review (construction for bathrooms)	2017	5,992						19
20	Shower Upgrade (plumbing/electrical/HVAC all units)	2017	250,744						20
21									21
22	Financial Statement Depreciation					368,987	368,987	9,723,497	22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 16,310,699	$		$ 368,987	$ 368,987	$ 9,723,497	34

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

Facility Name & ID Number St. Patrick's Residence # 0035006 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	$ 5,007,918	$	$ 208,358	$ 208,358		$ 3,793,781	71
72	Current Year Purchases	213,291		10,249	10,249		4,192,259	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 5,221,209	$	$ 218,607	$ 218,607		$ 7,986,040	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				10	49,512	77
78		2008 Silverado Pickup	2008	23,591		1,180	1,180	10	23,591	78
79		See Attached		14,913		1,146	1,146	10	11,880	79
80	TOTALS			$ 100,042	$	$ 2,326	$ 2,326		$ 97,009	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)	$ 22,270,540	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)	$ 589,920	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 589,920	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 17,806,546	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. Patrick's Residence # 0035006 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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

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: $ 3,212 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. Patrick's Residence # 0035006 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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.

STATE OF ILLINOIS

Facility Name & ID Number St. Patrick's Residence # 0035006 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	10-3	hrs	$		$ 369,418	$		$ 369,418	1
2	Licensed Speech and Language Development Therapist	10-3	hrs			191,925			191,925	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10-3	hrs			168,006			168,006	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				290,470		290,470	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):	39-3					162,499		162,499	12
13	Other (specify):									13
14	TOTAL			$		$ 729,349	$ 452,969		$ 1,182,318	14

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

STATE OF ILLINOIS

Facility Name & ID Number St. Patrick's Residence **#** 0035006 **Report Period Beginning:** 01/01/2017 **Ending:** 12/31/2017

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2017 **(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	$ 1,896,562	$	1
2	Cash-Patient Deposits	7,806		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 710,079)	1,963,168		3
4	Supply Inventory (priced at)	55,088		4
5	Short-Term Investments			5
6	Prepaid Insurance	35,202		6
7	Other Prepaid Expenses	17,237		7
8	Accounts Receivable (owners or related parties)	904,826		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,879,889	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	8,308,107		12
13	Land	638,590		13
14	Buildings, at Historical Cost	15,862,141		14
15	Leasehold Improvements, at Historical Cost	234,951		15
16	Equipment, at Historical Cost	5,817,905		16
17	Accumulated Depreciation (book methods)	(14,348,859)		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	345,678		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 16,858,513	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 21,738,402	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 408,252	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	7,806		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	693,421		30
31	Accrued Taxes Payable (excluding real estate taxes)	9,500		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	1,628,090		36
37	Other - See B37	1,223,709		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,970,778	$	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)**	$ 3,970,778	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 17,767,627	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 21,738,405	$	48

***(See instructions.)**

Facility Name & ID Number St. Patrick's Residence **#** 0035006 **Report Period Beginning:** 01/01/2017 **Ending:** 12/31/2017

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 17,466,912	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 17,466,912	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	300,715	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)**	$ 300,715	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)**	$ 17,767,627	24 *

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

Facility Name & ID Number St. Patrick's Residence # 0035006 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	$ 16,944,195	1
2	Discounts and Allowances for all Levels	(4,595,142)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 12,349,053	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,633,921	6
7	Oxygen	12,276	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,646,197	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	67,365	12
13	Barber and Beauty Care	47,067	13
14	Non-Patient Meals	5,154	14
15	Telephone, Television and Radio	13,075	15
16	Rental of Facility Space	99,859	16
17	Sale of Drugs	340,595	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	49,633	19
20	Radiology and X-Ray	15,360	20
21	Other Medical Services	325,424	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 963,532	23
	D. Non-Operating Revenue		
24	Contributions	1,717,689	24
25	Interest and Other Investment Income***	849,117	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,566,806	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	80,331	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 80,331	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 17,605,919	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	3,084,849	31
32	Health Care	8,089,157	32
33	General Administration	4,341,249	33
	B. Capital Expense		
34	Ownership	598,110	34
	C. Ancillary Expense		
35	Special Cost Centers	726,128	35
36	Provider Participation Fee	466,778	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 17,306,271	40
41	**Income before Income Taxes (line 30 minus line 40)****	299,648	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 299,648	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,759,406	44
45	Private Pay - Net Inpatient Revenue	5,704,415	45
46	Medicare - Net Inpatient Revenue	421,613	46
47	Other-(specify)	5,325	47
48	Other-(specify)	3,458,294	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 12,349,053	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. Patrick's Residence # 0035006 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	2,024	2,104	$ 102,054	$ 48.50	1
2	Assistant Director of Nursing	1,983	2,063	93,252	45.20	2
3	Registered Nurses	72,076	75,676	2,483,155	32.81	3
4	Licensed Practical Nurses	31,863	33,463	794,072	23.73	4
5	CNAs & Orderlies	186,502	194,227	2,198,652	11.32	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,536	7,836	130,172	16.61	8
9	Activity Director	1,901	1,981	49,552	25.01	9
10	Activity Assistants	17,436	18,111	252,984	13.97	10
11	Social Service Workers	8,275	8,595	171,069	19.90	11
12	Dietician	2,217	2,297	56,230	24.48	12
13	Food Service Supervisor	3,376	3,496	106,632	30.50	13
14	Head Cook	4,457	4,682	78,976	16.87	14
15	Cook Helpers/Assistants	57,166	59,416	705,168	11.87	15
16	Dishwashers					16
17	Maintenance Workers	16,005	16,605	317,902	19.14	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,945	2,025	101,069	49.91	20
21	Assistant Administrator	2,080	2,160	96,165	44.52	21
22	Other Administrative	31,229	32,729	824,502	25.19	22
23	Office Manager					23
24	Clerical	7,830	8,070	218,375	27.06	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					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	455,901	475,536	$ 8,779,981 *	$ 18.46	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	30,329	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		17,437	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		1,510	10-3	44
45	Social Service Consultant				45
46	Other(specify) Revenue Cycle	22	5,935		46
47	Admission from foreign hospital	0	73		47
48	Computer Support		3,427		48
49	TOTAL (lines 35 - 48)	143	$ 58,711		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	273	$ 32,050	10-3	50
51	Licensed Practical Nurses	5,028	193,043	10-3	51
52	Certified Nurse Assistants/Aides	16,596	360,781	10-3	52
53	TOTAL (lines 50 - 52)	21,897	$ 585,874		53

Facility Name & ID Number St. Patrick's Residence # 0035006 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Marilyn Daley	Administrator	0	$ 101,069
Sr. Anthony Veilleux	Asst. Administrator	0	96,165
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 197,234

B. Administrative - Other

Description	Amount
Carmelite System Dues	$ 170,601
TOTAL (agree to Schedule V, line 17, col. 3)	$ 170,601
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Nixon Peabody	Legal	$ 43,913
Polsinelli PC	Legal	938
CLA	Audit/Tax	33,326
Carmelite System made payment	Legal	738
Paycor	Payroll	12,322
Practical System Solutions	Consulting	3,427
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 94,664

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 208,044
Unemployment Compensation Insurance	50,685
FICA Taxes	634,287
Employee Health Insurance	949,520
Employee Meals	25,530
Illinois Municipal Retirement Fund (IMRF)*	
Pension	100,148
Life & Disability	58,816
Staff Development	29,148
Gifts and Events	9,981
EAP	2,148
Onboarding and Uniforms	4,816
Parking and Auto	165
TOTAL (agree to Schedule V, line 22, col.8)	$ 2,073,288

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 2,200
Advertising: Employee Recruitment	39,774
Health Care Worker Background Check	1,680
(Indicate # of checks performed 245)	
Patient Background Checks	2,450
Dues/Subsriptions/License	68,843
Advertising	29,010
Less: Public Relations Expense	(35,258)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 108,699

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 14,650
In-State Travel	
Seminar Expense	2,640
Non-allowable adjustment Pg. 5a	(17,290)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number St. Patrick's Residence # 0035006 **Report Period Beginning:** 01/01/2017 **Ending:** 12/31/2017

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 $17,355**

(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. $ **84,653** 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. $ **466,778**
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. $ **5,154**

(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