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: 036723

Facility Name: St Vincent's Home Inc.

Address: 1440 North 10th Street (Number) Quincy (City) 62301 (Zip Code)

County: Adams

Telephone Number: 217-224-3780 **Fax #** 217-224-3057

HFS ID Number:

Date of Initial License for Current Owners: 10/01/1990

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Dave Reis **Telephone Number:** 217-228-1950
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)
(Title)

Paid Preparer
(Signed) (Date)
(Print Name and Title) David Reis, President
(Firm Name & Address) WDM Support Services, 1900 Harrison Street Quincy IL 6231
(Telephone) 217-228-1950 Fax # 217-222-6053

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 Vincent's Home Inc. # 036723 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	90	Skilled (SNF)	90	32,850	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	90	TOTALS	90	32,850	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	13,954	7,780	3,194	24,928	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,954	7,780	3,194	24,928	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 75.88%

D. How many bed reserve days during this year were paid by the Department?
none (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? yes

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

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

I. On what date did you start providing long term care at this location?
Date started 10/01/1990

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 10/01/1990 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 90 and days of care provided 3,194

Medicare Intermediary CGS

IV. ACCOUNTING BASIS

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

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

Tax Year: 2017 Fiscal Year: _____

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

Facility Name & ID Number St Vincent's Home Inc. # 036723 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	233,268	23,394	7,953	264,615		264,615		264,615			1
2	Food Purchase		211,454		211,454	(978)	210,476	(8,361)	202,115			2
3	Housekeeping	135,934	21,825		157,759		157,759		157,759			3
4	Laundry	43,168	10,733	18	53,919		53,919		53,919			4
5	Heat and Other Utilities			81,371	81,371		81,371		81,371			5
6	Maintenance	85,190	26,730	41,394	153,314		153,314		153,314			6
7	Other (specify):*											7
8	**TOTAL General Services**	497,560	294,136	130,736	922,432	(978)	921,454	(8,361)	913,093			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	1,788,300	111,249	37,957	1,937,506		1,937,506	(99)	1,937,407			10
10a	Therapy			380,023	380,023		380,023		380,023			10a
11	Activities	68,066	6,266	18,331	92,663		92,663		92,663			11
12	Social Services	65,786		26,317	92,103		92,103		92,103			12
13	CNA Training											13
14	Program Transportation		5,762		5,762		5,762	(2,509)	3,253			14
15	Other (specify):* **Penalty**			6,127	6,127		6,127	(6,127)				15
16	**TOTAL Health Care and Programs**	1,922,152	123,277	474,755	2,520,184		2,520,184	(8,735)	2,511,449			16
	C. General Administration											
17	Administrative	96,100			96,100		96,100	(6,000)	90,100			17
18	Directors Fees											18
19	Professional Services			174,948	174,948		174,948	(76,307)	98,641			19
20	Dues, Fees, Subscriptions & Promotions			58,139	58,139		58,139	(32,739)	25,400			20
21	Clerical & General Office Expenses	204,235	14,148	44,159	262,542		262,542	562	263,104			21
22	Employee Benefits & Payroll Taxes			511,086	511,086	978	512,064		512,064			22
23	Inservice Training & Education			1,450	1,450		1,450		1,450			23
24	Travel and Seminar			7,722	7,722		7,722	250	7,972			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			54,233	54,233		54,233		54,233			26
27	Other (specify):* **sales tax**			572	572		572	(572)				27
28	**TOTAL General Administration**	300,335	14,148	852,309	1,166,792	978	1,167,770	(114,806)	1,052,964			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,720,047	431,561	1,457,800	4,609,408		4,609,408	(131,902)	4,477,506			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 Vincent's Home Inc. #036723 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			208,411	208,411		208,411	(2,496)	205,915			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			151,189	151,189		151,189	(2,225)	148,964			32
33	Real Estate Taxes			46,798	46,798		46,798	(267)	46,531			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* **income tax**			330	330		330	(330)				36
37	**TOTAL Ownership**			406,728	406,728		406,728	(5,318)	401,410			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		155,040	12,511	167,551		167,551		167,551			39
40	Barber and Beauty Shops			6,424	6,424		6,424		6,424			40
41	Coffee and Gift Shops			8,843	8,843		8,843	(6,968)	1,875			41
42	Provider Participation Fee			184,646	184,646		184,646		184,646			42
43	Other (specify):* **Bad Debts**			60,276	60,276		60,276	(60,276)				43
44	**TOTAL Special Cost Centers**		155,040	272,700	427,740		427,740	(67,244)	360,496			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,720,047	586,601	2,137,228	5,443,876		5,443,876	(204,464)	5,239,412			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 Vincent's Home Inc. # 036723 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	(5,425)	2		4
5	Telephone, TV & Radio in Resident Rooms	(120)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients	(99)	10		7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(2,496)	30		9
10	Interest and Other Investment Income	(2,225)	32		10
11	Discounts, Allowances, Rebates & Refunds	(2,936)	2		11
12	Non-Working Officer's or Owner's Salary	(69,996)	19		12
13	Sales Tax	(572)	27		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions	(6,000)	17		15
16	Personal Expenses (Including Transportation)	(2,509)	14		16
17	Non-Care Related Fees	(6,968)	41		17
18	Fines and Penalties	(6,127)	15		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(480)	20		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(60,276)	43		24
25	Fund Raising, Advertising and Promotional	(32,604)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(330)	36		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule Prpty Tax	(267)	33		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (199,430)		$	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)**	$ (5,034)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (204,464)		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					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS **Page 5A**

St Vincent's Home Inc.

ID# **036723**

Report Period Beginning: **01/01/2017**

Ending: **12/31/2017**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	2015 capitol improvement adj	$ (2,496)	30	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
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**	(2,496)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number St Vincent's Home Inc. # 036723 **Report Period Beginning:** 01/01/2017 **Ending:** 12/31/2017

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(8,361)	0	0	0	0	0	0	0	0	0	0	(8,361)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(8,361)	0	0	0	0	0	0	0	0	0	0	(8,361)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(99)	0	0	0	0	0	0	0	0	0	0	(99)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(2,509)	0	0	0	0	0	0	0	0	0	0	(2,509)	14
15	Other (specify):*	(6,127)	0	0	0	0	0	0	0	0	0	0	(6,127)	15
16	**TOTAL Health Care and Programs**	(8,735)	0	0	0	0	0	0	0	0	0	0	(8,735)	16
	C. General Administration													
17	Administrative	(6,000)	0	0	0	0	0	0	0	0	0	0	(6,000)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(69,996)	(6,311)	0	0	0	0	0	0	0	0	0	(76,307)	19
20	Fees, Subscriptions & Promotions	(33,084)	345	0	0	0	0	0	0	0	0	0	(32,739)	20
21	Clerical & General Office Expenses	(120)	682	0	0	0	0	0	0	0	0	0	562	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	250	0	0	0	0	0	0	0	0	0	250	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(572)	0	0	0	0	0	0	0	0	0	0	(572)	27
28	**TOTAL General Administration**	(109,772)	(5,034)	0	0	0	0	0	0	0	0	0	(114,806)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(126,868)	(5,034)	0	0	0	0	0	0	0	0	0	(131,902)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number St Vincent's Home Inc. # 036723 **Report Period Beginning:** 01/01/2017 **Ending:** 12/31/2017

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(4,992)	0	0	0	0	0	0	0	0	0	0	(4,992)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,225)	0	0	0	0	0	0	0	0	0	0	(2,225)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	(330)	0	0	0	0	0	0	0	0	0	0	(330)	36
37	**TOTAL Ownership**	(7,547)	0	0	0	0	0	0	0	0	0	0	(7,547)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	(6,968)	0	0	0	0	0	0	0	0	0	0	(6,968)	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(60,276)	0	0	0	0	0	0	0	0	0	0	(60,276)	43
44	**TOTAL Special Cost Centers**	(67,244)	0	0	0	0	0	0	0	0	0	0	(67,244)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(201,659)	(5,034)	0	0	0	0	0	0	0	0	0	(206,693)	45

Facility Name & ID Number St Vincent's Home Inc. # 036723 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
Carlyle Healthcare Center Inc.	100	Carlyle Healthcare Inc.	Carlyle	WDM Health Services	Quincy	Management
		Clinton Manor	New Baden			

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

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

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	Management	$ 43,500	WDMHealth Services Inc.	0.00%	$ 32,348	$ (11,152)	1
2	V	19	Accounting				2,254	2,254	2
3	V	19	Legal				2,587	2,587	3
4	V	20	Subscriptions				345	345	4
5	V	21	Office				675	675	5
6	V	21	Postage				7	7	6
7	V	24	Travel				250	250	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 43,500			$ 38,466	$ * (5,034)	14

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

Facility Name & ID Number St Vincent's Home Inc. # 036723 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								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number St Vincent's Home Inc. # 036723 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	Ann Reis	Secretary	St. Vincents			10	20.00		$		1
2	Sue Gray	Treasurer	St. Vincents			10	20.00				2
3	David Reis	President	St. Vincents			10	20.00				3
4	Carlyle Healthcare owns 100 % of the St. Vincents Stock			100.00							4
5	Ann Reis	Secretary	Carlyle Healthcare	45.00		10	20.00				5
6	Sue Gray	Treasurer	Carlyle Healthcare	50.00		10	20.00				6
7	David Reis	President	Carlyle Healthcare			10	20.00				7
8	Ann Reis		Clinton Manor			2	4.00				8
9	WDM Health Services	Managemnet Fees						MGMT Fees	43,500	19-3	9
10	Chris Reis	VP Operations	St.Vincents/Carlyle	5.00	110,160				31,215	17-1	10
11	Janeane reis	HR Director	St.Vincents/Carlyle		65,765				49,945	22-1	11
12											12
13								TOTAL	$ 124,660		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 Vincent's Home Inc. # 036723 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 [X] NO [ ]

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

Name of Related Organization: WDM Health Services Inc.
Street Address: 1900 Harrison
City / State / Zip Code: Quincy Il 62301
Phone Number: (217-228-1950
Fax Number: (217-222-6053

	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	19	Managemnet	Patient Days	57,797	2	$ 75,000	$ 75,000	24,928	$ 32,348	1
2	19	Accounting	Patient Days	57,797	2	5,225		24,928	2,254	2
3	19	Legal	Patient Days	57,797	2	5,998		24,928	2,587	3
4	20	Subscriptions	Patient Days	57,797	2	800		24,928	345	4
5	21	Office	Patient Days	57,797	2	1,564		24,928	675	5
6	21	Postage	Patient Days	57,797	2	17		24,928	7	6
7	24	Travel	Patient Days	57,797	2	580		24,928	250	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					$ 89,184	$ 75,000		$ 38,466	25

Facility Name & ID Number St Vincent's Home Inc. # 036723 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	First Bankers Trust		X	Mortgage	$21,014.00	01/20/17	$ 3,220,000	$ 2,925,432	01/20/18	4.8500	$ 116,173	1
2												2
3												3
4												4
5												5
	Working Capital											
6	First Bankers Trust		X	Line of credit		05/24/17		673,410	05/26/18	5.0000	34,891	6
7												7
8	Turtle Top Financing		X	Van Loan	$772.27	01/18/13	44,135	1,576	01/17/18	1.9000	124	8
9	TOTAL Facility Related				$21,786.27		$ 3,264,135	$ 3,600,418			$ 151,188	9
	B. Non-Facility Related*											
10	Interest Income										(2,225)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (2,225)	14
15	TOTALS (line 9+line14)						$ 3,264,135	$ 3,600,418			$ 148,963	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 Vincent's Home Inc. # 036723 **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.**	$	58,748	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 46531	2
3. Under or (over) accrual (line 2 minus line 1).	$	12,217	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)	$	46,064	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.	$	46,798	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2012	57,943	8
	2013	58,748	9
	2014	57,760	10
	2015	57,822	11
	2016	46,531	12

Prperty Tax adj (267)

	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 Vincent's Home Inc. COUNTY Adams

FACILITY IDPH LICENSE NUMBER 036723

CONTACT PERSON REGARDING THIS REPORT Vickie Summers

TELEPHONE 217-224-3780 FAX #: 217-224-3827

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.	23-7-0068-000-00	Nursing Home	$ 46,531.00	$ 46,531.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 46,531.00	$ 46,531.00

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 Vincent's Home Inc. # 036723 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 38,109 B. General Construction Type: Exterior Brick Frame cinder block/steel Number of Stories 2

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).

Assisted Living 10 units
Katherin Kasper Village 26 Units
Katherin Kasper Community Center
Katherine Kasper CILA 4 bedroom unit

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	Nursing Home	114,177	1990	$ 61,500	1
2					2
3	TOTALS	114,177		$ 61,500	3

Facility Name & ID Number St Vincent's Home Inc. # 036723 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	67		1990	1976	$ 963,000	$ 33,123	30	$ 33,123	$	$ 871,985	4
5	13		1999	1998	878,056	31,646	30	31,646		532,591	5
6											6
7											7
8											8
	Improvement Type**										
9	LAUNDRY ROOM			1999	68,109					68,109	9
10	GLASS ENCLOSER			1990	2,972					2,972	10
11	DINNING ROOM ADDITION			1991	86,996					86,996	11
12	GARAGE			1991	35,000					35,000	12
13	LAND IMPROVEMENTS			1991	13,130					13,130	13
14	CONCRETE DRVWY LOT 1			1993	10,580					10,580	14
15	FIREWALL			1993	1,808					1,808	15
16	CONCRETE DRVWYLOT 2			1997	83,961					83,961	16
17	NEW ROOF			1997	82,806	4,733	20	2,801	(1,932)	85,607	17
18	LANDSCAPING			1997	10,358					10,358	18
19	ROOFTOP A/C UNITS			1997	6,995					6,995	19
20	HANDRAILS			1998	11,165					11,165	20
21											21
22	REMODELING HALLWAYS			1998	26,569					26,569	22
23	FIRE DAMPERS			1999	7,122					7,122	23
24	8 PATIENT ROOM REMODELING			1999	11,018					11,018	24
25	LEVEL BUILDING			2000	74,150	3,743	20	3,743		65,728	25
26	DOORS CLOSERS,NEW VENTILATION, ELECTRICAL			2000	15,450					15,450	26
27	RAILING			2000	2,997					2,997	27
28	WATER HEATER			2000	4,851					4,851	28
29	LAND IMPROVEMENTS			2001	4,522					4,522	29
30	NEW KITCHEN			2001	55,641	214	15	214		54,873	30
31											31
32	SMOKE DECTORS			2002	2,562					562	32
33											33
34	NEW HOT/COLD WATER LINES 100/200 WINGS			2005	29,851	995	30	995		12,106	34
35	LANDSCSPING/PARKING LOT LIGHTS			2006	55,446	2,789	20	2,789		30,578	35
36	ROOF HTG/AC			2008	3,976	265	15	265		2,607	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 Vincent's Home Inc. # 036723 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	Emergency Wiring	2009	$ 6,400	$ 320	20	$ 320	$	$ 2,674	37
38	Dietary A/C	2010	6,570	821	8	821		6,090	38
39	500 Wing Zone Control	2010	15,512	1,034	15	1,034		7,756	39
40	5 Ton A/C	2010	7,319	488	15	488		3,741	40
41									41
42	New Nurse Station for 300/500 wing	2011	11,871	791	15	791		5,012	42
43	Roof Top A/C	2012	5,282	660	8	660		3,862	43
44	Sprinkler Replacement for 100/200 wing	2012	32,010	2,134	15	2,134		11,025	44
45	Outside Freezor/Refrigertor	2012	21,770	1,451	15	1,451		7,619	45
46	400 Wing Dementia unit drywall/steel studs	2012	10,206	865	15	684	(181)	3,818	46
47	400Wing Dementia doors/windows	2012	11,565	771	15	771		4,047	47
48	400 Wing Dementia electrical	2012	12,505	834	15	834		4,376	48
49	400 Wing Dementia Paint	2012	572	38	15	38		200	49
50	400 Wing Dementia patio/steel fence/concrete	2012	10,045	670	15	670		3,515	50
51	400Wing Dementia plumbing	2012	3,594	240	15	240		1,258	51
52	400 Wing Dementia ceiling/insulation	2012	6,701	447	15	447		2,345	52
53	400 Wing Dementia sprinkler/smoke/fire alarms	2012	3,652	243	15	243		1,278	53
54	400 Wing Dementia wonder guard security	2012	11,708	781	15	781		1,097	54
55	300 Wing Plumbing	2013	24,049	1,603	15	1,603		6,547	55
56	300 Wing Materilas /Labor	2013	42,981	3,190	15	2,807	(383)	12,260	56
57	300 Wing Flooring	2013	12,441	829	15	829		3,386	57
58	5 new roof top units	2014	38,695	2,580	15	2,580		8,384	58
59	LED ceiling lights	2015	16,364	818	20	818		2,318	59
60	Shingle Roof 100/200 wing	2015	43,000	2,150	20	2,150		6,087	60
61	Flat Roof 300/400/500 wings	2015	74,500	3,725	20	3,725		9,623	61
62	dinning room a/c	2016	11,445	1,434	8	1,434		2,120	62
63	dinning rm windows	2016	3,793	474	8	474		672	63
64	dinning rm doors/ceiling	2016	9,021	1,128	8	1,128		1,222	64
65	generator	2017	84,073	467	15	467		467	65
66	generator wiring/concrete/labor/materials	2017	48,335	269	15	269		269	66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,135,070	$ 108,763		$ 106,267	$ (2,496)	$ 2,183,308	70

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

Facility Name & ID Number St Vincent's Home Inc. # 036723 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	$ 698,870	$ 79,672	$ 79,672	$	8	$ 500,386	71
72	Current Year Purchases	83,602	5,853	5,853		8	5,853	72
73	Fully Depreciated Assets	98,275					98,275	73
74								74
75	TOTALS	$ 880,747	$ 85,525	$ 85,525	$		$ 604,514	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	Facility	2015 chev equonix	2016	$ 25,696	$ 5,139	$ 5,139	$	5	$ 10,278	76
77	Facility	2000 GMC Truck Plow	2009	12,000					12,000	77
78	Facility	2000 Chev Van	2000	40,067					40,067	78
79	Facility	2013 Dodge Van	2013	44,135	8,984	8,984		5	44,135	79
80	TOTALS			$ 121,898	$ 14,123	$ 14,123	$		$ 106,480	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)	$ 4,199,215	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 208,411	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 205,915	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (2,496)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,894,302	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 Vincent's Home Inc. # 036723 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:
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: $ 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 Vincent's Home Inc. # 036723 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 Vincent's Home Inc. # 036723 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	10a-3	hrs	$		$ 129,005	$		$ 129,005	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs			65,295			65,295	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs			185,723			185,723	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				155,040		155,040	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Lab	39-3				12,511			12,511	12
13	Other (specify):									13
14	TOTAL			$		$ 392,534	$ 155,040		$ 547,574	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 Vincent's Home Inc. **#** 036723 **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	$ (297,518)	$ (318,912)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,712,553	1,829,129	3
4	Supply Inventory (priced at FIFO)	65,630	65,630	4
5	Short-Term Investments			5
6	Prepaid Insurance	60,565	66,106	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,541,230	$ 1,641,953	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	61,500	127,282	13
14	Buildings, at Historical Cost	3,000,930	5,468,400	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,203,819	1,663,509	16
17	Accumulated Depreciation (book methods)	(2,878,596)	(4,183,044)	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 (spe Goodwil		46,126	22
23	Other(specify): CIP		120,779	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,387,653	$ 3,243,052	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,928,883	$ 4,885,005	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 86,878	$ 86,878	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	223,176	354,020	29
30	Accrued Salaries Payable	120,067	120,067	30
31	Accrued Taxes Payable (excluding real estate taxes)	53,214	53,214	31
32	Accrued Real Estate Taxes(Sch.IX-B)	46,064	60,106	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	(6,447)	(6,447)	35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 522,952	$ 667,838	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	2,925,432	2,925,432	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	line of credit	673,411	673,411	43
44	deferred income trusts		367,058	44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 3,598,843	$ 3,965,901	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,121,795	$ 4,633,739	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,192,912)	$ 251,266	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,928,883	$ 4,885,005	48

***(See instructions.)**

Facility Name & ID Number St Vincent's Home Inc. # 036723 **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**	$ 311,224	1
2	Restatements (describe):		2
3	2016 Adjustments	(11,812)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 299,412	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(148,903)	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) Other Divisions	100,757	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (48,146)	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)**	$ 251,266	24 *

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

Facility Name & ID Number St Vincent's Home Inc. # 036723 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	$ 5,009,607	1
2	Discounts and Allowances for all Levels	90,843	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,100,450	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	150,273	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 150,273	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	856	12
13	Barber and Beauty Care	6,067	13
14	Non-Patient Meals	5,425	14
15	Telephone, Television and Radio	120	15
16	Rental of Facility Space		16
17	Sale of Drugs	2,139	17
18	Sale of Supplies to Non-Patients	99	18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 14,706	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,225	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,225	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	see attached list	27,319	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 27,319	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,294,973	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	922,432	31
32	Health Care	2,520,184	32
33	General Administration	1,166,792	33
	B. Capital Expense		
34	Ownership	406,728	34
	C. Ancillary Expense		
35	Special Cost Centers	243,094	35
36	Provider Participation Fee	184,646	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,443,876	40
41	**Income before Income Taxes (line 30 minus line 40)****	(148,903)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (148,903)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,810,330	44
45	Private Pay - Net Inpatient Revenue	1,656,844	45
46	Medicare - Net Inpatient Revenue	1,633,276	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,100,450	49

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

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

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

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

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,800	2,088	$ 78,027	$ 37.37	1
2	Assistant Director of Nursing					2
3	Registered Nurses	16,296	17,934	455,007	25.37	3
4	Licensed Practical Nurses	22,121	23,854	490,140	20.55	4
5	CNAs & Orderlies	57,592	61,275	711,149	11.61	5
6	CNA Trainees	4,546	4,998	53,977	10.80	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,936	2,088	27,507	13.17	9
10	Activity Assistants	3,751	4,124	40,559	9.83	10
11	Social Service Workers	3,846	4,236	65,786	15.53	11
12	Dietician					12
13	Food Service Supervisor	2,014	2,140	42,145	19.69	13
14	Head Cook					14
15	Cook Helpers/Assistants	13,175	14,094	148,898	10.56	15
16	Dishwashers	4,190	4,349	42,225	9.71	16
17	Maintenance Workers	4,700	4,861	85,190	17.53	17
18	Housekeepers	12,526	13,589	135,933	10.00	18
19	Laundry	4,286	4,420	43,168	9.77	19
20	Administrator	1,484	1,637	64,886	39.64	20
21	Assistant Administrator					21
22	Other Administrative	2,088	2,088	31,215	14.95	22
23	Office Manager					23
24	Clerical	7,784	8,372	157,331	18.79	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) marketing	1,948	2,087	46,904	22.47	33
34	TOTAL (lines 1 - 33)	166,083	178,234	$ 2,720,047 *	$ 15.26	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	136	$ 7,298	1-3	35
36	Medical Director		6,000	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	66	1,141	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	9	4,081	11-3	44
45	Social Service Consultant	42	26,317	12-3	45
46	Other(specify) Religious		14,250	11-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	253	$ 59,087		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number St Vincent's Home Inc. # 036723 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Vickie Summers	Adm		$ 64,885
Chris reis	VP Operations	5	31,215
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 96,100

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
		$
Herman Bodewes	Legal	54,672
SB@	Legal	
Reis Security	Seurity monitoring	2,400
WDM Healthcare	Management	43,500
Time Track	PR software	4,380
WDM Support	Act/data proc/payroll	69,996
see pag 6		(6,311)
non allow		(69,996)
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 98,641

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 95,341
Unemployment Compensation Insurance	21,698
FICA Taxes	200,784
Employee Health Insurance	185,420
Employee Meals	978
Illinois Municipal Retirement Fund (IMRF)*	
Employee physicals	2,673
401k plan fees	5,170
TOTAL (agree to Schedule V, line 22, col.8)	$ 512,064

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	$
Advertising: Employee Recruitment	13,817
Health Care Worker Background Check	2,010
(Indicate # of checks performed 22)	
Patient Background Checks 178	1,394
Advertising	32,604
Ill Sec of state	1,233
IHCA	7,080
see pg 6	345
PAC non Allow	(480)
Less: Public Relations Expense	( )
Non-allowable advertising	(32,604)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 25,399

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
see attached list	7,722
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 7,722

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number St Vincent's Home Inc. # 036723 **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. **IHCA 7080**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **Yes** If YES, have these costs
been properly adjusted out of the cost report? **480**

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

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **8yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **37,559** Line **10-2**

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

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

(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 fo
Schedule VII)? YES NO **X** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen
during this cost report period. $ **184,646**
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 tc
the Department, in addition to the daily rate, been properly classifiec
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 fo
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. $ **978** Has any meal income been offset against
related costs? **Yes** Indicate the amount. $ **5,425**

(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 fo
residents? **No** If YES, please indicate the amount of income earned from such a
program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100**
d. Have vehicle usage logs been maintained?
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? N
Indicate the amount of income earned from providing such
transportation during this reporting period. $

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

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