FOR BHF USE

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2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0020495

Facility Name: Brother James Court

Address: 2508 St James Road (Number) Springfield (City) 62707 (Zip Code)

County: Sangamon

Telephone Number: 217-544-4676 **Fax #** 217-474-5914

HFS ID Number:

Date of Initial License for Current Owners: October 1, 1975

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: Sonia Bartels **Telephone Number:** 217-747-5906
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/1/17 to 6/30/18 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) Sonia Bartels
(Title) Administrator

Paid Preparer

(Signed) (Date)
(Print Name and Title) Richard Lynch, Partner
(Firm Name & Address) Sikich LLP, 3201 West White Oaks Drive
(Telephone) 217-793-3363 Fax # 217-862-3529

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 Brother James Court # 0020495 Report Period Beginning: 7/1/17 Ending: 6/30/18

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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	99	Intermediate (ICF)	99	36,135	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	99	TOTALS	99	36,135	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					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	32,978	153		33,131	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	32,978	153		33,131	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.69%

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? Yes

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

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

I. On what date did you start providing long term care at this location?
Date started 10/1/1975

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

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

Medicare Intermediary _____

IV. ACCOUNTING BASIS

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

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

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

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

STATE OF ILLINOIS

Facility Name & ID Number Brother James Court # 0020495 Report Period Beginning: 7/1/17 Ending: 6/30/18

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	211,753	20,167	8,415	240,335		240,335		240,335			1
2	Food Purchase		240,028		240,028		240,028		240,028			2
3	Housekeeping	60,091	24,614		84,705		84,705		84,705			3
4	Laundry	51,954	7,739		59,693		59,693		59,693			4
5	Heat and Other Utilities			164,121	164,121		164,121		164,121			5
6	Maintenance	94,049	14	72,490	166,553		166,553		166,553			6
7	Other (specify):*											7
8	TOTAL General Services	417,847	292,562	245,026	955,435		955,435		955,435			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,596,740	81,823	32,333	1,710,896		1,710,896		1,710,896			10
10a	Therapy			14,784	14,784		14,784		14,784			10a
11	Activities	53,762			53,762		53,762		53,762			11
12	Social Services	171,536	1,211	7,200	179,947		179,947		179,947			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Pharmacist & Dietary			8,293	8,293		8,293		8,293			15
16	TOTAL Health Care and Programs	1,822,038	83,034	62,610	1,967,682		1,967,682		1,967,682			16
	C. General Administration											
17	Administrative	85,647			85,647		85,647	(85,647)				17
18	Directors Fees											18
19	Professional Services			141,522	141,522		141,522		141,522			19
20	Dues, Fees, Subscriptions & Promotions			13,888	13,888		13,888		13,888			20
21	Clerical & General Office Expenses	212,022	25,523	180,216	417,761		417,761	(4,488)	413,273			21
22	Employee Benefits & Payroll Taxes			364,323	364,323		364,323		364,323			22
23	Inservice Training & Education											23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			61,613	61,613		61,613		61,613			26
27	Other (specify):*											27
28	TOTAL General Administration	297,669	25,523	761,562	1,084,754		1,084,754	(90,135)	994,619			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,537,554	401,119	1,069,198	4,007,871		4,007,871	(90,135)	3,917,736			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 Brother James Court #0020495 Report Period Beginning: 7/1/17 Ending: 6/30/18

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			155,510	155,510		155,510	98,490	254,000			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			310,700	310,700		310,700	(310,500)	200			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			466,210	466,210		466,210	(212,010)	254,200			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			249,120	249,120		249,120		249,120			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			249,120	249,120		249,120		249,120			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,537,554	401,119	1,784,528	4,723,201		4,723,201	(302,145)	4,421,056			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 Brother James Court # 0020495 Report Period Beginning: 7/1/17 Ending: 6/30/18

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				4
5	Telephone, TV & Radio in Resident Rooms				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				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(4,488)	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				24
25	Fund Raising, Advertising and Promotional	(85,647)	17		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (90,135)		$	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)	(212,010)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (212,010)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (302,145)		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

Brother James Court

ID# 0020495

Report Period Beginning: 7/1/17

Ending: 6/30/18

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
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
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	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Brother James Court # 0020495 Report Period Beginning: 7/1/17 Ending: 6/30/18

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	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**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	(85,647)	0	0	0	0	0	0	0	0	0	0	(85,647)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(4,488)	0	0	0	0	0	0	0	0	0	0	(4,488)	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	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(90,135)	0	0	0	0	0	0	0	0	0	0	(90,135)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(90,135)	0	0	0	0	0	0	0	0	0	0	(90,135)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Brother James Court # 0020495 **Report Period Beginning:** 7/1/17 **Ending:** 6/30/18

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	98,490	0	0	0	0	0	0	0	0	0	98,490	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(310,500)	0	0	0	0	0	0	0	0	0	(310,500)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	(212,010)	0	0	0	0	0	0	0	0	0	(212,010)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(90,135)	(212,010)	0	0	0	0	0	0	0	0	0	(302,145)	45

Facility Name & ID Number Brother James Court # 0020495 Report Period Beginning: 7/1/17 Ending: 6/30/18

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
N/A	N/A	N/A	N/A	Franciscan Brothers of	Springfield	Religious Order
N/A	N/A	N/A	N/A	Springfield Developme	Springfield	Day Training Progra
N/A	N/A	N/A	N/A	Weber Care Corporati	Springfield	Community Living F

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	34	Facility Rent	$ 310,500	Franciscan Brothers of the Holy Cross	100.00%	$	$ (310,500)	1
2	V	30	Depreciation		Franciscan Brothers of the Holy Cross	100.00%	98,490	98,490	2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 310,500			$ 98,490	$ * (212,010)	14

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

Facility Name & ID Number Brother James Court # 0020495 Report Period Beginning: 7/1/17 Ending: 6/30/18

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 Brother James Court # 0020495 Report Period Beginning: 7/1/17 Ending: 6/30/18

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									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

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

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

Facility Name & ID Number Brother James Court # 0020495 Report Period Beginning: 7/1/17 Ending: 6/30/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Brother James Court # 0020495 Report Period Beginning: 7/1/17 Ending: 6/30/18

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							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Illinois National Bank		X	Line of Credit	None	9/2/2018			9/2/2019	6.2500	195	6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 195	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$ 195	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 Brother James Court # 0020495 Report Period Beginning: 7/1/17 Ending: 6/30/18

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 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 2018 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:		
	2013	8
	2014	9
	2015	10
	2016	11
	2017	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2017	$	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.

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Brother James Court COUNTY Sangamon

FACILITY IDPH LICENSE NUMBER 0020495

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 2017 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 2017.

	(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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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 Brother James Court # 0020495 Report Period Beginning: 7/1/17 Ending: 6/30/18

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 47,210 B. General Construction Type: Exterior Brick/stone Frame Steel Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (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: N/A 2. Number of Years Over Which it is Being Amortized: N/A

3. Current Period Amortization: N/A 4. Dates Incurred: N/A

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				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number Brother James Court # 0020495 Report Period Beginning: 7/1/17 Ending: 6/30/18

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			1975	1975	$ 1,003,250	$	30	$	$	$ 1,003,250	4
5			1996	1996	1,251,493		30	41,716	41,716	896,903	5
6			1997	1997	1,256,490		30	41,883	41,883	842,309	6
7											7
8											8
	Improvement Type**										
9	BJC REPAVING PARKING LOT			1986	42,236		10			42,236	9
10	BJC BLDG. IMPROVEMENTS			1980	16,233		11			16,233	10
11	BJC BLDG. IMPROVEMENTS			1984	21,419		10			21,419	11
12	BJC VARIOUS			1987	69,555		10			69,555	12
13	INSULATION			1991	9,175		15			9,175	13
14	BJC - STEAM LINE			1985	14,479		10			14,479	14
15	BJC - BLDG. IMPROVEMENTS			1975	19,600		24			19,600	15
16	BJC - SIDEWALK/PATIO			1976	3,545		10			3,545	16
17	BJC BIKE RINK			1978	2,500		5			2,500	17
18	BJC SITE IMPROVEMENT			1979	1,440		26			1,440	18
19	BJC ROOF			1979	12,166		10			12,166	19
20	BJC VARIOUS DONATED			1988	46,656		10			46,656	20
21	BJC WATER LINE			1989	3,166		20			3,166	21
22	SEWAGE TREATMENT PLANT			1990	6,411		20			6,411	22
23	TANK REMOVAL			1991	9,809		10			9,809	23
24	PARKING LOT			1992	10,453		10			10,453	24
25	REPAVING PARKING LOT			1994	850		10			850	25
26	PUMP			1994	734		10			734	26
27	BJC LAND IMP. - TREES			1996	3,470		20			3,470	27
28	BJC - IMPROVEMENTS			1998	15,712		30	524	524	10,387	28
29	BJC - NEW WING CHANGE ORDERS			1997	18,883		30	629	629	12,956	29
30	WATER LINE REPAIR			1999	3,102		10			3,102	30
31	BJC LAND IMP - TREES			1999	25,849		20	1,292	1,292	23,695	31
32	GATE			1999	550		5			550	32
33	BJC			1999	5,773		10			5,773	33
34	FLOOR			2000	1,683		7			1,683	34
35	Roof - Laundry Bldg			2011	6,493		10	649	649	3,950	35
36	SDC Patio Concrete			2011	7,385		10	739	739	4,739	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 Brother James Court # 0020495 Report Period Beginning: 7/1/17 Ending: 6/30/18

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	Fire Alarm System - Chapel	2011	$ 1,551	$	10	$ 155	$ 155	$ 931	37
38	Chapel Plaster Repair & Painting	2011	31,508		10	3,151	3,151	18,905	38
39	Driveway Pavement - Missouri House	2011	6,800		10	680	680	4,363	39
40	Landscaping	2011	7,157		10	716	716	4,652	40
41	Fence - SDC Bldg	2011	2,375		10	238	238	1,504	41
42	Chapel Renovations - Entrance Lighting	2011	11,150		10	1,115	1,115	7,526	42
43	Light Fixtures for BJC Building	2011	1,321		10	132	132	815	43
44	Bell Tower Roof	2011	7,960		10	796	796	5,174	44
45	BJC Water Line	1987	14,120		20			14,120	45
46	Boiler Room Consulting	1993	15,106		20			15,106	46
47	Boiler Room Project	1994	170,330		20			170,330	47
48	Boiler Room Remodeling	1992	12,498		20			12,498	48
49	Total Life Center 2	1998	122,261		30	4,075	4,075	79,809	49
50	LEASEHOLD IMPROVEMENTS	1985	15,200		10			15,200	50
51	LEASEHOLD IMPROVEMENTS	1986	19,507		10			19,507	51
52	PAINTING	1987	9,922		3			9,922	52
53	STEEL DOOR	1987	6,020		10			6,020	53
54	CORRIDOR WINDOW REMOVAL	1987	2,013		10			2,013	54
55	EMERGENCY GEN. SWITCH	1988	3,335		10			3,335	55
56	REMODEL LOBBY	1989	156,996	5,233	30	5,233		149,583	56
57	BUS HUT	1989	4,715		15			4,715	57
58	HOT WTR-HTR	1989	6,721		10			6,721	58
59	TRANSFER SWITCH	1989	1,127		10			1,127	59
60	HEAT-ENERGY PANEL	1989	8,633		10			8,633	60
61	ROOF REPAIR	1990	6,928		10			6,928	61
62	REMODELING	1990	6,953	232	30	232		6,528	62
63	OVERHEAD DOOR	1990	1,220		10			1,220	63
64	KITCHEN TANKS	1990	3,089		10			3,089	64
65	NEW PLASTER	1990	1,649		10			1,649	65
66	PLASTERING	1990	937		10			937	66
67	REMODEL CEILING	1990	2,970		10			2,970	67
68	OFFICE SIGNS	1990	170		10			170	68
69	ROOF REPAIR	1990	2,200		10			2,200	69
70	TOTAL (lines 4 thru 69)		$ 4,555,002	$ 5,465		$ 103,954	$ 98,490	$ 3,691,393	70

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

Facility Name & ID Number Brother James Court # 0020495 Report Period Beginning: 7/1/17 Ending: 6/30/18

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		$ 4,555,002	$ 5,465		$ 103,954	$ 98,490	$ 3,691,393	1
2	LEASEHOLD IMPROVEMENT	1990	8,762		10			8,762	2
3	LEASEHOLD IMPROVEMENT	1990	11,633		10			11,633	3
4	LEASEHOLD IMPROVEMENT	1990	3,250		10			3,250	4
5	CHAIR FABRIC	1991	25		5			25	5
6	GYM LOUNGES SEAT REPAIR	1991	44		5			44	6
7	DRAPES	1991	289		5			289	7
8	DRAPES	1991	908		5			908	8
9	INSTALLATION OF TILE	1991	876		10			876	9
10	FURNISH/INSTALL WINDOW REPLACEMENTS	1992	2,750		10			2,750	10
11	CAFETERIA DOORS	1993	11,918		10			11,918	11
12	PLUMBING WORK	1994	6,858		10			6,858	12
13	REPAIR WALLS AND DOORS	1995	2,596		10			2,596	13
14	DOOR	1996	656		10			656	14
15	PAINTING	1996	1,620		3			1,620	15
16	FURNACE	1996	502		10			502	16
17	GRIP CAPS	1996	1,575		5			1,575	17
18	BEDDDING	1996	1,505		3			1,505	18
19	AIR DEFLECTORS	1996	381		3			381	19
20	SHOWER	1996	259		5			259	20
21	REMODELING	1996	4,928		10			4,928	21
22	ROOF REPAIR	1997	798		10			798	22
23	DRAPES	1997	4,500		5			4,500	23
24	FLOOR COVERINGS	1997	1,722		10			1,722	24
25	DRAPES - LIFE CENTER	1997	3,153		5			3,153	25
26	FLOOR COVERINGS - LIFE CENTER	1997	4,422		10			4,422	26
27	PAINTING - LIFE CENTER	1997	8,917		10			8,917	27
28	REDECORATE SNACK LOUNGE & AN OFFICE	1999	2,847		5			2,847	28
29	ROOF REPAIRS	1999	846		10			846	29
30	CARPET IN FRONT OFFICE	1999	8,881		5			8,881	30
31	YARD SIGNS	1999	2,825		10			2,825	31
32	VINYL WALL COVERING	1999	1,127		10			1,127	32
33	SHOWER ROOM REPAIRS	1999	8,220		10			8,220	33
34	TOTAL (lines 1 thru 33)		$ 4,664,594	$ 5,465		$ 103,954	$ 98,490	$ 3,800,986	34

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

Facility Name & ID Number Brother James Court # 0020495 Report Period Beginning: 7/1/17 Ending: 6/30/18

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 4,664,594	$ 5,465		$ 103,954	$ 98,490	$ 3,800,986	1
2	CONNECTION FEES FOR SEWER PROJECT	1998	7,438		10			7,438	2
3	TREE REMOVAL (23TREES)	1999	9,857		10			9,857	3
4	CONDENSER	1999	12,396		10			12,396	4
5	DROP ROD ASSEMBLY	1999	6,408		10			6,408	5
6	FENCING	1999	3,840		10			3,840	6
7	TREES	1999	9,905		10			9,905	7
8	ROOF REPAIRS	2000	2,300		10			2,300	8
9	TILE FLOOR - RESIDENT WINGS	2000	34,740		10			34,740	9
10	CABINET MODIFICATION	1999	4,520		7			4,520	10
11	HOLY CROSS - ELECTRICAL	1999	17,410		15			17,410	11
12	HOLY CROSS - SIGN	1999	900		5			900	12
13	HOLY CROSS - MASONRY	1999	23,465		15			23,465	13
14	HOLY CROSS - PLUMBING/HEATING	1999	31,000		15			31,000	14
15	HOLY CROSS - REMODELING	1999	19,524		15			19,524	15
16	PARKING LOT STRIPES	2000	1,549		5			1,549	16
17	PAINTING CEILING OF BASEMENT	2000	664		5			664	17
18	RAMP AREA DECORATING	2001	14,387		5			14,387	18
19	PAINTING & WALLCOVERING	2001	8,058		5			8,058	19
20	AIR CURTAIN	2001	1,812		7			1,812	20
21	RECEPTACLES - BEDROOMS	2001	9,820		5			9,820	21
22	SHOWER ROOM FLOOR REPAIR	2002	1,123		10			1,123	22
23	BOILER	2002	3,960		5			3,960	23
24	DRAPERIES - WING 400	2002	4,200		5			4,200	24
25	ARCHITECT FEES - MODERNIZE & ENLARGE BATHROOM	2002	9,863		3			9,863	25
26	REPAVE SIDEWALKS	2002	810		10			810	26
27	TUCKPOINTING	2002	1,490		10			1,490	27
28	TRILOGY KEYPAD LOCK	2002	580		10			580	28
29	HOT WATER STORAGE TANK - LAUNDRY	2002	4,409		10			4,409	29
30	DOORS & FRAMES	2003	3,733		10			3,733	30
31	POLE LIGHTING - WEST PARKING LOT	2003	3,740	249	15	249		3,636	31
32	SINK FAUCET & CABINET	2004	1,133		7			1,133	32
33	WALLPAPERING/PAINTING	2004	2,358	157	15	157		2,201	33
34	TOTAL (lines 1 thru 33)		$ 4,921,985	$ 5,871		$ 104,361	$ 98,490	$ 4,058,116	34

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

Facility Name & ID Number Brother James Court # 0020495 Report Period Beginning: 7/1/17 Ending: 6/30/18

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 12D, Carried Forward		$ 5,414,367	$ 26,663		$ 125,152	$ 98,490	$ 4,404,653	1
2	Repaving Track	2009	8,400		7			8,400	2
3	Wing 300 Bathroom Renovation	2009	44,169		7			44,169	3
4	Repave Walking Path	2009	1,450		7			1,450	4
5	Repair Brick on Garage	2009	12,330	1,233	10	1,233		10,789	5
6	Replace hot & Chilled Water Piping W400	2009	12,968		7			12,968	6
7	Sewer Station Construction of Trash Rack	2009	15,375		7			15,375	7
8	Extending Mains to Good Pipe W200	2009	2,787		7			2,787	8
9	Repair Boiler Room Roof	2010	15,462	515	30	515		4,252	9
10									10
11	Light Fixtures for Front Entrance	2010	4,791		5			4,791	11
12	Water Heater	2011	16,761	1,676	10	1,676		11,872	12
13	Roof Repairs	2011	6,804	680	10	680		4,763	13
14	Sewer Grinder	2010	23,908	2,391	10	2,391		18,528	14
15	Roof	2010	19,800	990	20	990		7,755	15
16	Bathroom Tile	2010	1,200	120	10	120		900	16
17	Cabinets	2011	1,867		5			1,867	17
18	Sidewalk	2010	4,169	417	10	417		3,231	18
19	Drain	2010	3,611	361	10	361		2,889	19
20	Outside Lighting	2010	4,184		5			4,184	20
21	Doors	2010	4,169	417	10	417		3,300	21
22	Front Sidewalk	2010	8,850	885	10	885		6,933	22
23	Front door operators	2010	11,541	1,154	10	1,154		9,041	23
24	Front Door Electric	2010	2,119	212	10	212		1,642	24
25	Sealcoat Parking Lot	2011	3,500	233	15	233		1,614	25
26	Garage Door	2011	6,577	329	20	329		2,275	26
27	Concrete	2011	4,465	298	15	298		2,034	27
28	Hose and Cart	2011	113	11	10	11		77	28
29	Sidewalk	2011	8,250	825	10	825		5,637	29
30	Garage Window	2011	6,875	688	10	688		4,641	30
31	Kitchen Cabinets	2011	3,980	398	10	398		2,653	31
32	Countertops, Formica	2011	1,120	56	20	56		373	32
33	Alarm Video	2012	5,998	600	10	600		3,799	33
34	TOTAL (lines 1 thru 33)		$ 5,681,960	$ 41,152		$ 139,641	$ 98,490	$ 4,609,642	34

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

Facility Name & ID Number Brother James Court # 0020495 Report Period Beginning: 7/1/17 Ending: 6/30/18

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 12C, Carried Forward		$ 4,921,985	$ 5,871		$ 104,361	$ 98,490	$ 4,058,116	1
2	DOORS	2004	4,987	332	15	332		4,710	2
3	CEILING FAN	2004	1,082		7			1,082	3
4	ELECTRIC WORK	2004	16,000	1,067	15	1,067		14,933	4
5	ALARM SYSTEM	2004	2,204		7			2,204	5
6	Parking lot	2004	3,443		10			3,443	6
7	BOILER - KITCHEN STEAMER	2004	4,871		7			4,871	7
8	BOILER	2004	6,900		7			6,900	8
9	BOILER	2004	7,200		7			7,200	9
10	HVAC LABOR AND MATERIAL FOR 2ND FLOOR	2004	12,497		7			12,497	10
11	PARKING LOT	2004	74,847	2,495	30	2,495		34,721	11
12	DENTIST'S OFFICE RENOVATION	2004	57,955	1,932	30	1,932		26,563	12
13	POLE LIGHT REPLACEMENT	2004	1,868		7			1,868	13
14	STORAGE ROOM	2004	2,375		7			2,375	14
15	BATHROOM REPAIRS	2005	4,232		5			4,232	15
16	ALARM FOR BUILDING	2005	3,000		10			3,000	16
17	ALARM FOR BUILDING	2005	3,041		10			3,041	17
18	ROOF	2005	22,370	1,119	20	1,119		14,074	18
19	WATER HEATER	2006	32,250		10			32,250	19
20	Boiler	2006	4,611		7			4,611	20
21	Bathroom Repairs	2006	6,959		7			6,959	21
22	Generator	2007	2,814		5			2,814	22
23	Alarm for Building	2007	3,325		10			3,325	23
24	New Roof	2007	90,882	3,029	30	3,029		33,071	24
25	Exterior Flood Lilght	2008	945	16	10	16		945	25
26	New Water Heater	2009	71,300	7,130		7,130		67,735	26
27	A/C Unit - Nursing Station, break room	2009	7,934	793		793		7,471	27
28	Alarm System Upgrades	2009	1,240	124		124		1,147	28
29	Power Supply for new A/C Unit	2009	1,443					1,443	29
30	Prof fees - New hot water system	2009	5,600					5,600	30
31	A/C Rooftop Unit	2009	27,544	2,754		2,754		24,790	31
32	Bath room renovation	2009	3,346					3,346	32
33	Seal & Stripe Parking Lot	2009	3,315					3,315	33
34	TOTAL (lines 1 thru 33)		$ 5,414,367	$ 26,663		$ 125,152	$ 98,490	$ 4,404,653	34

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

Facility Name & ID Number Brother James Court # 0020495 Report Period Beginning: 7/1/17 Ending: 6/30/18

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 12E, Carried Forward		$ 5,681,960	$ 41,152		$ 139,641	$ 98,490	$ 4,609,642	1
2	Double Doors	2012	2,552	170	15	170		1,078	2
3	Drapery	2012	2,564	256	10	256		1,603	3
4	Curtain Rod	2012	96	10	10	10		60	4
5	Window (Plant Service Building)	2012	15,208	1,521	10	1,521		9,125	5
6	Tile Removal	2012	5,260	526	10	526		3,068	6
7	Floor Tile	2012	4,200	420	10	420		2,450	7
8	Heat Exchanger	2012	15,664	1,044	15	1,044		6,005	8
9	Fire Sprinkler	2012	44,209	2,210	5	2,210		44,209	9
10	Fire Alarm System	2013	40,199	4,690	5	4,690		40,199	10
11	Fire Alarm Garage	2013	5,374	985	5	985		5,374	11
12	Surveillance Cameras	2013	10,135	1,448	7	1,448		7,240	12
13	Video Cameras	2013	5,040	720	7	720		3,600	13
14	Tank Sump Pump Lid	2013	4,396	440	10	440		2,161	14
15	Horizontal Boiler Feed Water	2013	15,670	2,239	7	2,239		10,447	15
16	Fire Alarm Plant Service/Garage	2013	9,133	1,827	5	1,827		8,220	16
17	Parking Lot Lighting	2014	5,380	359	15	359		1,405	17
18	B&G Electric Pump	2014	644	43	15	43		168	18
19	Nurse Door Alarm	2015	13,343	890	15	890		2,965	19
20	Door Alarm	2015	11,764	784	15	784		2,549	20
21	Door Alarm	2015	17,837	1,189	15	1,189		3,766	21
22	office carpet	2015	3,340	334	10	334		1,141	22
23	TV Wall mount	2015	448	64	7	64		218	23
24	light fixture	2015	1,142	163	7	163		517	24
25	Clear Glass for Windows (10)	2000	2,009		10			2,009	25
26	Floors - Wing 500	2002	2,688		10			2,688	26
27	Lighting	2015	10,670	1,524	7	1,524		4,700	27
28	A/C Doctors office	2015	5,468	547	10	547		1,595	28
29	wiring phone fiber optics	2015	1,159	166	7	166		469	29
30	A/C electrical room	2015	5,376	538	10	538		1,523	30
31	heating valves	2015	2,558	365	7	365		974	31
32	Security cameras	2016	2,975	425	7	425		1,027	32
33	boiler contactor pump 1	2016	422	60	7	60		151	33
34	TOTAL (lines 1 thru 33)		$ 5,948,882	$ 67,108		$ 165,597	$ 98,490	$ 4,782,344	34

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

Facility Name & ID Number Brother James Court # 0020495 Report Period Beginning: 7/1/17 Ending: 6/30/18

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 12F, Carried Forward		$ 5,948,882	$ 67,108		$ 165,597	$ 98,490	$ 4,782,344	1
2	boiler contractor pump 2	2016	422	60	7	60		151	2
3	CHILLER	2017	80,673	8,067	10	8,067		10,756	3
4	LANDSCAPING	2017	8,595	860	10	860		1,003	4
5	ACCESS CONTROL	2017	2,989	299	10	299		349	5
6	PARKING LOT LIGHTS	2016	4,960	496	10	496		744	6
7	Compressor	2016	6,081	608	10	608		1,014	7
8	Door	2017	1,914	191	10	191		191	8
9	Alarms/Smoke Detector	1998	20,108					20,108	9
10	Boiler	1996	3,335					3,335	10
11	Door Repairs	2002	6,197					6,197	11
12	Draperies	2001	10,881					10,881	12
13	Floor	1997	2,658					2,658	13
14	Land Improvements	1996	1,385					1,385	14
15	LANDSCAPING	1999	18,255					18,255	15
16	Leasehold Improvements 3	1999	5,754					5,754	16
17	Leasehold Improvements	1999	2,598					2,598	17
18	Leasehold Imp	1999	6,629					6,629	18
19	New Tees & Valves	1999	11,685					11,685	19
20	Painting	1995	3,076					3,076	20
21	Painting	2000	6,352					6,352	21
22	Parking Lot Security System	2000	20,404					20,404	22
23	Repairs	1996	10,702					10,702	23
24	Roof Repair	1996	5,985					5,985	24
25	Sewer	1996	9,387					9,387	25
26	Strip/Refinish Floor	2002	8,702					8,702	26
27	**Toilet Room Addition/Reno**	2004	699,826	23,328		23,328		338,963	27
28	New AC Units	2018	2,112	79		79		79	28
29	Firestop above wing 200 doors	2018	4,175	104		104		104	29
30	Water seperator for chilled water	2018	6,041	25		25		25	30
31	Maglock on front door	2018	2,733	456		456		456	31
32									32
33									33
34	**TOTAL (lines 1 thru 33)**		$ 6,923,495	$ 101,681		$ 200,170	$ 98,490	$ 5,290,271	34

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

Facility Name & ID Number Brother James Court # 0020495 Report Period Beginning: 7/1/17 Ending: 6/30/18

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	$ 322,799	$ 42,105	$ 42,105	$	various	$ 156,857	71
72	Current Year Purchases	47,336	1,973	1,973		various	1,973	72
73	Fully Depreciated Assets	1,860,791				various	1,860,791	73
74								74
75	TOTALS	$ 2,230,926	$ 44,078	$ 44,078	$		$ 2,019,621	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 Use	Truck - Fully Depreciated	2011	$ 9,500	$	$	$	5	$ 9,500	76
77	Resident Transportation	Van	various	61,875	6,350	6,350		5	35,275	77
78	Resident Transportation	Auto - Fully Depreciated	various	136,680				5	136,680	78
79	Resident Transportation	Car and Cart	various	17,006	3,401	3,401		5	9,640	79
80	TOTALS			$ 225,061	$ 9,751	$ 9,751	$		$ 191,095	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)	$ 9,379,482	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 155,510	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 253,999	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 98,490	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 7,500,987	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 Brother James Court # 0020495 Report Period Beginning: 7/1/17 Ending: 6/30/18

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Franciscan Brothers of the Holy Cross

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 [X] 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 [X] NO Terms: *

10. Effective dates of current rental agreement:
Beginning 1975
Ending 2019

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2019	$ 310,500
13.		$
14.		$

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

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ None 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 Brother James Court # 0020495 Report Period Beginning: 7/1/17 Ending: 6/30/18

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? [X] YES [ ] 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 [X]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER CNA 40

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- HOURS PER CNA 80

B. EXPENSES

ALLOCATION OF COSTS (d)

			1	2	3	4
			Facility			
			Drop-outs	Completed	Contract	Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies			502		502
3	Classroom Wages	(a)		7,189		7,189
4	Clinical Wages	(b)		11,674		11,674
5	In-House Trainer Wages	(c)		800		800
6	Transportation					
7	Contractual Payments					
8	CNA Competency Tests					
9	TOTALS		$	$ 20,165	$	$ 20,165
10	SUM OF line 9, col. 1 and 2	(e)	$ 20,165			

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	21
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	21

(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.

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	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 Brother James Court # 0020495 Report Period Beginning: 7/1/17 Ending: 6/30/18

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 6/30/18 (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	$ 790,297	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	481,195		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	530,846		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	40,852		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,843,190	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	2,170,748		12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	2,637,811		15
16	Equipment, at Historical Cost	2,455,987		16
17	Accumulated Depreciation (book methods)	(4,062,061)		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):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,202,485	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,045,675	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 811,548	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	97,500		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Vacation	21,565		36
37	Accrued Pension	81,510		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,012,123	$	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)**	$ 1,012,123	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 4,033,552	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,045,675	$	48

*(See instructions.)

Facility Name & ID Number Brother James Court # 0020495 Report Period Beginning: 7/1/17 Ending: 6/30/18

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,952,431	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,952,431	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	81,121	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)**	$ 81,121	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)**	$ 4,033,552	24 *

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

Facility Name & ID Number Brother James Court # 0020495 Report Period Beginning: 7/1/17 Ending: 6/30/18

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	$ 4,202,295	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,202,295	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	42,310	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	13,482	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 55,792	23
	D. Non-Operating Revenue		
24	Contributions	301,419	24
25	Interest and Other Investment Income***	223,439	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 524,858	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Gain on disposal of asset	800	28
28a	Misc Income	20,577	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 21,377	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,804,322	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	955,435	31
32	Health Care	1,967,682	32
33	General Administration	1,084,754	33
	B. Capital Expense		
34	Ownership	466,210	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	249,120	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,723,201	40
41	**Income before Income Taxes (line 30 minus line 40)****	81,121	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 81,121	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,344,519	44
45	Private Pay - Net Inpatient Revenue	18,923	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) Social Security Benefits and SSI Benefits	788,071	47
48	Other-(specify) Insurance and other Third Party Payments	50,782	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,202,295	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 Brother James Court # 0020495 Report Period Beginning: 7/1/17 Ending: 6/30/18

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	2,279	2,279	$ 66,913	$ 29.36	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,755	4,755	142,937	30.06	3
4	Licensed Practical Nurses	17,122	17,122	357,596	20.89	4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	4,083	4,083	53,762	13.17	9
10	Activity Assistants					10
11	Social Service Workers	2,080	2,080	42,814	20.58	11
12	Dietician					12
13	Food Service Supervisor	1,923	1,923	29,181	15.17	13
14	Head Cook					14
15	Cook Helpers/Assistants	18,845	18,845	182,572	9.69	15
16	Dishwashers					16
17	Maintenance Workers	5,475	5,475	94,049	17.18	17
18	Housekeepers	5,363	5,363	60,091	11.20	18
19	Laundry	4,195	4,195	51,954	12.38	19
20	Administrator	2,080	2,080	85,647	41.18	20
21	Assistant Administrator					21
22	Other Administrative	12,991	12,991	212,022	16.32	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	8,115	8,115	128,722	15.86	28
29	Resident Services Coordinator	1,920	1,920	49,294	25.67	29
30	Habilitation Aides (DD Homes)	93,446	93,446	949,659	10.16	30
31	Medical Records	2,119	2,119	30,341	14.32	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	186,791	186,791	$ 2,537,554 *	$ 13.58	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	various	$ 8,415	1, 3	35
36	Medical Director				36
37	Medical Records Consultant	various	32,333	10, 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	various	8,293	15, 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	various	7,200	12, 3	45
46	Other(specify)				46
47	Psychologist Consultant	various	14,784	10a, 3	47
48					48
49	TOTAL (lines 35 - 48)		$ 71,025		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 Brother James Court # 0020495 Report Period Beginning: 7/1/17 Ending: 6/30/18

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Sonia Bartels	Administrator	0	$ 85,647
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 85,647

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
Sikich	Audit/Accounting	$ 20,605
Legal	Legal	113,003
INB	Trust/Fiduciary Fees	6,065
Illinois Health Care Assoc	Advocacy	1,849
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 141,522

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 75,232
Unemployment Compensation Insurance	58,342
FICA Taxes	189,564
Employee Health Insurance	
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Life Insurance	10,973
401K Contribution	19,500
Continuing Education	924
Staff Recognition	793
Employee Physical	8,995
TOTAL (agree to Schedule V, line 22, col.8)	$ 364,323

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	10,828
Health Care Worker Background Check	1,024
(Indicate # of checks performed)	
Patient Background Checks	
Dues and Subscriptions	2,036
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 13,888

G. Schedule of Travel and Seminar**

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

**See instructions.

Facility Name & ID Number Brother James Court # 0020495 Report Period Beginning: 7/1/17 Ending: 6/30/18

XX. GENERAL INFORMATION:

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

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

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

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

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **9**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **0** Line **N/A**

(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. $ **249,120**
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. $ **None** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **Yes**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **Yes** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **13,482**
c. What percent of all travel expense relates to transportation of nurses and patients? **100**
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? **No**
Firm Name: **N/A**

(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