		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: 0035006

Facility Name: St. Patrick's Residence

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

County: DuPage

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

HFS ID Number:

Date of Initial License for Current Owners:

Type of Ownership:

- [x] VOLUNTARY,NON-PROFIT
  - [x] Charitable Corp.
  - [ ] Trust
- [ ] PROPRIETARY
  - [ ] Individual
  - [ ] Partnership
  - [ ] Corporation
  - [ ] "Sub-S" Corp.
  - [ ] Limited Liability Co.
  - [ ] Trust
  - [ ] Other
- [ ] GOVERNMENTAL
  - [ ] State
  - [ ] County
  - [ ] Other

IRS Exemption Code

In the event there are further questions about this report, please contact:
Name: Deborah D. Freeland **Telephone Number:** (317) 569-6230
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/18 to 12/31/18 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) Marilyn Daley
(Title) Administrator

Paid Preparer

(Signed) 4/26/19 (Date)
(Print Name and Title) Deborah D Freeland, CPA, Principal
(Firm Name & Address) CliftonLarsonAllen LLP, 9365 Counselors Row, Suite 200 Indianapolis, IN 46240
(Telephone) (317) 574-9100 Fax # (317) 574-9707

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

Facility Name & ID Number St. Patrick's Residence # 0035006 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	206	Skilled (SNF)	206	75,190	1
2		Skilled Pediatric (SNF/PED)			2
3	3	Intermediate (ICF)	3	1,095	3
4		Intermediate/DD			4
5	1	Sheltered Care (SC)	1	365	5
6		ICF/DD 16 or Less			6
7	210	TOTALS	210	76,650	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	36,500	21,087	5,888	63,475	8
9	SNF/PED					9
10	ICF	122	768		890	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	36,622	21,855	5,888	64,365	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.97%

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 05/22/1989

J. Was the facility purchased or leased after January 1, 1978?
YES [x] Date 05/22/1989 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 206 and days of care provided 64,365

Medicare Intermediary NGS

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

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

Tax Year: 12/31/2018 Fiscal Year: 12/31/2018

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

Facility Name & ID Number St. Patrick's Residence # 0035006 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	796,531	60,506	30,225	887,262		887,262		887,262			1
2	Food Purchase		478,737		478,737		478,737	(30,446)	448,291			2
3	Housekeeping		2,768	803,246	806,014		806,014		806,014			3
4	Laundry		1,403		1,403		1,403		1,403			4
5	Heat and Other Utilities			385,597	385,597		385,597	(9,808)	375,789			5
6	Maintenance	321,663		76,751	398,414		398,414		398,414			6
7	Other (specify):*											7
8	**TOTAL General Services**	1,118,194	543,414	1,295,819	2,957,427		2,957,427	(40,254)	2,917,173			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	5,720,979	255,113	1,158,702	7,134,794		7,134,794		7,134,794			10
10a	Therapy	105,608		866,030	971,638		971,638		971,638			10a
11	Activities	254,895	20,722	16,984	292,601		292,601		292,601			11
12	Social Services	133,113	4,150	33,987	171,250		171,250		171,250			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	6,214,595	279,985	2,075,703	8,570,283		8,570,283		8,570,283			16
	C. General Administration											
17	Administrative	115,811		177,156	292,967		292,967		292,967			17
18	Directors Fees											18
19	Professional Services			41,087	41,087		41,087		41,087			19
20	Dues, Fees, Subscriptions & Promotions			97,900	97,900		97,900	(36,550)	61,350			20
21	Clerical & General Office Expenses	539,497	78,631	862,211	1,480,339		1,480,339	(327,152)	1,153,187			21
22	Employee Benefits & Payroll Taxes			2,087,518	2,087,518		2,087,518		2,087,518			22
23	Inservice Training & Education											23
24	Travel and Seminar			5,187	5,187		5,187	(5,187)				24
25	Other Admin. Staff Transportation			12,522	12,522		12,522	(12,522)				25
26	Insurance-Prop.Liab.Malpractice			199,193	199,193		199,193		199,193			26
27	Other (specify):*											27
28	**TOTAL General Administration**	655,308	78,631	3,482,774	4,216,713		4,216,713	(381,411)	3,835,302			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	7,988,097	902,030	6,854,296	15,744,423		15,744,423	(421,665)	15,322,758			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number St. Patrick's Residence #0035006 Report Period Beginning: 01/01/18 Ending: 12/31/18

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			737,783	737,783		737,783		737,783			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			44,256	44,256		44,256	(44,256)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			19,591	19,591		19,591		19,591			35
36	Other (specify):*											36
37	**TOTAL Ownership**			801,630	801,630		801,630	(44,256)	757,374			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		236,135	199,445	435,580		435,580		435,580			39
40	Barber and Beauty Shops	23,624	13,699		37,323		37,323		37,323			40
41	Coffee and Gift Shops		16,931		16,931		16,931	(16,931)				41
42	Provider Participation Fee			479,180	479,180		479,180		479,180			42
43	Other (specify):*	155,017		123,052	278,069		278,069	(278,069)				43
44	**TOTAL Special Cost Centers**	178,641	266,765	801,677	1,247,083		1,247,083	(295,000)	952,083			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	8,166,738	1,168,795	8,457,603	17,793,136		17,793,136	(760,921)	17,032,215			45

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

Facility Name & ID Number St. Patrick's Residence # 0035006 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	(30,446)	2		4
5	Telephone, TV & Radio in Resident Rooms	(9,808)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	(86,114)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(44,256)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(2,697)	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	(169,487)	21		24
25	Fund Raising, Advertising and Promotional	(30,344)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(387,769)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (760,921)		$	30

BHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (760,921)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

St. Patrick's Residence

ID# 0035006

Report Period Beginning: 01/01/18

Ending: 12/31/18

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Coffee/Gift Shop Expense	$ (16,931)	41	1
2	Investment Fees	(68,854)	21	2
3	Development Salaries	(155,017)	43	3
4	Fundraising/Special Events Expense	(123,052)	43	4
5	Continuing Education	(5,187)	24	5
6	Non-allowable Travel	(12,522)	25	6
7	Lobbying Fees	(6,206)	20	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(387,769)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number St. Patrick's Residence # 0035006 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	(30,446)	0	0	0	0	0	0	0	0	0	0	(30,446)	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	(9,808)	0	0	0	0	0	0	0	0	0	0	(9,808)	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**	(40,254)	0	0	0	0	0	0	0	0	0	0	(40,254)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(36,550)	0	0	0	0	0	0	0	0	0	0	(36,550)	20
21	Clerical & General Office Expenses	(327,152)	0	0	0	0	0	0	0	0	0	0	(327,152)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(5,187)	0	0	0	0	0	0	0	0	0	0	(5,187)	24
25	Other Admin. Staff Transportation	(12,522)	0	0	0	0	0	0	0	0	0	0	(12,522)	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**	(381,411)	0	0	0	0	0	0	0	0	0	0	(381,411)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(421,665)	0	0	0	0	0	0	0	0	0	0	(421,665)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number St. Patrick's Residence # 0035006 **Report Period Beginning:** 01/01/18 **Ending:** 12/31/18

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	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(44,256)	0	0	0	0	0	0	0	0	0	0	(44,256)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(44,256)	0	0	0	0	0	0	0	0	0	0	(44,256)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	(16,931)	0	0	0	0	0	0	0	0	0	0	(16,931)	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(278,069)	0	0	0	0	0	0	0	0	0	0	(278,069)	43
44	**TOTAL Special Cost Centers**	(295,000)	0	0	0	0	0	0	0	0	0	0	(295,000)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(760,921)	0	0	0	0	0	0	0	0	0	0	(760,921)	45

Facility Name & ID Number St. Patrick's Residence # 0035006 Report Period Beginning: 01/01/18 Ending: 12/31/18

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

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	Management Fees	$ 177,156		100.00%	$ 177,156	$	1
2	V	21	Sister Compensation	34,233		100.00%	34,233		2
3	V	12	Sister Compensation	23,363		100.00%	23,363		3
4	V	21	Sister Compensation	98,713		100.00%	98,713		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			$ 333,465			$ 333,465	$ *	14

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

Facility Name & ID Number St. Patrick's Residence # 0035006 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	Carmelite Sisters for the Aged and	100	None		Carmelite Sisters	Germantown, NY	Religious Order	1
2	Infirm, Inc.				for the Aged and Infirm, Inc.			2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number St. Patrick's Residence # 0035006 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	Sr. M. Teresa Kathleen Domin	Director							$		1
2	Daniel Short, MD	Director									2
3	Sr. Mary Rose Heery	President									3
4	Sr. Patricia Rawdon	Vice President									4
5	John Durso	Secretary									5
6	Marilyn Daley	Treasurer									6
7	Mr. William H. Hayes	Director									7
8	Charles Millington	Chairman									8
9	Sr. Alice Webster	Director									9
10	Raymond Jones	Director									10
11	Rev James Lennon	Director									11
12	Kathleen McGowan	Director									12
13								TOTAL	$		13

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

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

Facility Name & ID Number St. Patrick's Residence # 0035006 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 ☐

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

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

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

Facility Name & ID Number St. Patrick's Residence # 0035006 Report Period Beginning: 01/01/18 Ending: 12/31/18

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			X	Working Capital		07/01/17	800,000					6
7						06/01/18	600,000					7
8						09/21/18	400,000	400,000			44,256	8
9	TOTAL Facility Related						$ 1,800,000	$ 400,000			$ 44,256	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 1,800,000	$ 400,000			$ 44,256	15

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

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

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

Facility Name & ID Number St. Patrick's Residence # 0035006 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 St. Patrick's Residence COUNTY DuPage

FACILITY IDPH LICENSE NUMBER 0035006

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 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 St. Patrick's Residence # 0035006 Report Period Beginning: 01/01/18 Ending: 12/31/18

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

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

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	7.33 Acres	1987	$ 638,590	1
2					2
3	TOTALS	7.33 Acres		$ 638,590	3

Facility Name & ID Number St. Patrick's Residence # 0035006 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	210		1989	1989	$ 7,786,645	$		$	$	$	4
5			1997	1997	2,194,676						5
6			2000	2000	2,986,981						6
7			2005	2005	882,594						7
8											8
	Improvement Type**										
9	1991 Fixed Assets			1991	4,862						9
10	1993 Fixed Assets			1993	6,887						10
11	1994 Fixed Assets			1994	31,612						11
12	1996 Fixed Assets			1996	2,976						12
13	1997 Fixed Assets			1997	52,566						13
14	1998 Fixed Assets			1998	28,215						14
15	1999 Fixed Assets			1999	6,832						15
16	2000 Fixed Assets			2000	16,581						16
17	2001 Fixed Assets			2001	10,440						17
18	2002 Fixed Assets			2002	3,966						18
19	2005 Fixed Assets			2005	10,924						19
20	2006 Fixed Assets			2006	237,917						20
21	2007 Fixed Assets			2007	185,440						21
22	2008 Fixed Assets			2008	240,356						22
23	2009 Fixed Assets			2009	59,316						23
24	2010 Fixed Assets			2010	54,416						24
25	2011 Fixed Assets			2011	139,614						25
26	2012 Fixed Assets			2012	84,044						26
27	2013 Fixed Assets			2013	45,901						27
28	Ashland Door solutions			2014	11,627						28
29	Madden Glass/event room & 4 office Windows			2014	22,360						29
30	Madden Glass/ 16 Winvent screens			2014	1,317						30
31	Precision Piping for 1west heating/cooling			2014	7,403						31
32	Chapel Heat Exchanger			2014	10,250						32
33	Inpro Elevator Update			2015	8,259						33
34	Inpro Elevator Update			2015	6,246						34
35	Ashland Door solutions 1st half 2nd &3rd flo fire doors			2015	18,626						35
36	Ashland door solutions 2nd half 2nd&3rd flr fire doors			2015	21,371						36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

Facility Name & ID Number St. Patrick's Residence # 0035006 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	Westside Mechanical	2015	$ 5,116	$		$	$	$	37
38	Reliant Electrocal Electric for AC	2015	2,758						38
39	Gilkerson Masonary Convent outside repair	2015	11,410						39
40	Westside Mechanical Main Electric Room A/C	2015	18,950						40
41	Adler Plumbing & heating Inc/replace wite pipe/mixing valves	2015	15,320						41
42	Crowthers Roofing	2016	3,940						42
43	Chase Ink AV Ovrhd Door	2016	1,775						43
44	Reliant electric Relocation Circuit emergency	2016	3,960						44
45	Showalter Roofing (May & July)	2016	7,535						45
46	Nuyen industries Canope employee entrance	2016	8,250						46
47	Noland Sales Corp lobby & hall vinyl plank flooring	2016	27,809						47
48	Chase Ink AV Ovrhd Door -Convent 2nd installment	2016	1,775						48
49	NC Concrete Co.Asphalt replacement	2016	8,340						49
50	Ashland Door - Main Diningroom Doors	2017	603						50
51	Ashland Door - Bring maintenance doors up to code	2017	1,220						51
52	Showalter Roofing Services - Convent Roof	2017	1,199						52
53	Key Construction - Replace holding tanks	2017	6,122						53
54	Replacement pump for fire system	2017	685						54
55	Rogers Pump & Sales - Fire pump rebuild	2017	2,903						55
56	Tr from CIP - Cubicle Curtains	2017	2,487						56
57	Gilkerson Masonry Corp - Reseal Convent Masonry	2017	4,400						57
58	Preferred Window and Door - Upgrade sliding doors	2017	6,200						58
59	PH PH Roofing down payment	2017	89,533						59
60	PH Deposit - Replace Patio Door	2017	3,213						60
61	Perkins Eastman Architects - shower upgrade	2017	17,873						61
62	City of Naperville - Shower upgrade	2017	2,227						62
63	Mazur & Son Construction - shower upgrade	2017	349,259						63
64	FSES Survey	2017	3,750						64
65	Perkins Eastman Architects	2017	44,198						65
66	State of Illinois	2017	6,336						66
67	IDPH Plan Review (construction for bathrooms)	2017	5,992						67
68	Shower Upgrade	2017	250,744						68
69	Argueta's Landscaping - Staff Patio Project	2018	1,140						69
70	TOTAL (lines 4 thru 69)		$ 16,098,242	$		$	$	$	70

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

Facility Name & ID Number St. Patrick's Residence # 0035006 Report Period Beginning: 01/01/18 Ending: 12/31/18

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		$ 16,098,242	$		$	$	$	1
2	Ashland Door - Replace Patio Door	2018	3,123						2
3	Roofed Right America - Roofing Services	2018	89,533						3
4	Ashland Door - Install Pemko Door Shoes - life safety	2018	2,908						4
5	Jense Hughes - Life Safety Survey & Report	2018	4,000						5
6	Pete's Carpet Service - Office Carpeting	2018	790						6
7	Key Construction Group - Convent Plumbing	2018	2,529						7
8	State Mechanical Services - Chapel Condenser	2018	13,992						8
9	Sound Incorporated - Paging System upgrade	2018	8,475						9
10	Roofed Right America - Roofing Services	2018	82,084						10
11	ILLCO - Convent cold water supply run/piping	2018	2,252						11
12	Peerless Fence - Garden Fence	2018	14,985						12
13	Precision Control Systems - Convent water line	2018	3,110						13
14	Garden gate final bill - (Citizens cc)	2018	319						14
15	Sound Incorporated - Paging System upgrade	2018	5,733						15
16	Shower upgrade (from CIP)	2018	121						16
17	Hubert Menu Board	2018	588						17
18									18
19									19
20									20
21	Financial Statement Depreciation					407,629	407,629	10,491,632	21
22						67,236	67,236		22
23	PY Depreciation Expense Adjustment from audit								23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 16,332,783	$		$ 474,865	$ 474,865	$ 10,491,632	34

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

Facility Name & ID Number St. Patrick's Residence # 0035006 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	$ 222,515	$	$ 16,845	$ 16,845		$ 16,845	71
72	Current Year Purchases	5,181,008		245,273	245,273		4,012,812	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 5,403,523	$	$ 262,118	$ 262,118		$ 4,029,657	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		2001 Dodge Grand Caravan	2004	$ 12,026	$	$	$	5	$ 12,026	76
77		2008 Chevy Bus	2007	49,512				10	49,512	77
78		2018 Silverado Pickup	2008	23,591				10	23,591	78
79		See Attached		14,913		800	800	10	13,713	79
80	TOTALS			$ 100,042	$	$ 800	$ 800		$ 98,842	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 22,474,938	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 737,783	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 737,783	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 14,620,131	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number St. Patrick's Residence # 0035006 Report Period Beginning: 01/01/18 Ending: 12/31/18

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

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

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

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

	Fiscal Year Ending	Annual Rent
12.	/2019	$
13.	/2020	$
14.	/2021	$

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. Patrick's Residence # 0035006 Report Period Beginning: 01/01/18 Ending: 12/31/18

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?
   - [ ] 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.

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10-3	hrs	$ 284,929		$	$		$ 284,929	1
2	Licensed Speech and Language Development Therapist	10-3	hrs	204,562					204,562	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10-3	hrs	369,923					369,923	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				236,135		236,135	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):	39-3					199,445		199,445	12
13	Other (specify):									13
14	TOTAL			$ 859,414		$	$ 435,580		$ 1,294,994	14

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

Facility Name & ID Number St. Patrick's Residence # 0035006 Report Period Beginning: 01/01/18 Ending: 12/31/18

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/18 (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	$ 2,160,364	$	1
2	Cash-Patient Deposits	10,465		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,547,966		3
4	Supply Inventory (priced at)	62,622		4
5	Short-Term Investments	7,895,488		5
6	Prepaid Insurance	34,086		6
7	Other Prepaid Expenses	13,817		7
8	Accounts Receivable (owners or related parties)	2,365		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 11,727,173	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	638,590		13
14	Buildings, at Historical Cost	16,094,797		14
15	Leasehold Improvements, at Historical Cost	237,977		15
16	Equipment, at Historical Cost	6,040,422		16
17	Accumulated Depreciation (book methods)	(15,086,643)		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 CIP	338,689		22
23	Other(specify): A/R Non-Residents	1,039,698		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 9,303,530	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 21,030,703	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 488,887	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	10,465		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	704,064		30
31	Accrued Taxes Payable (excluding real estate taxes)	12,846		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to Related Party	1,368,958		36
37	Other - See B37	1,184,883		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,770,103	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,770,103	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 17,260,600	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 21,030,703	$	48

***(See instructions.)**

Facility Name & ID Number St. Patrick's Residence # 0035006 Report Period Beginning: 01/01/18 Ending: 12/31/18

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 17,767,627	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 17,767,627	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(506,918)	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) PY Adjustmnet	(109)	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (507,027)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 17,260,600	24 *

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

Facility Name & ID Number St. Patrick's Residence # 0035006 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	$ 18,525,393	1
2	Discounts and Allowances for all Levels	(5,489,100)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 13,036,293	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,899,745	6
7	Oxygen	12,439	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,912,184	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	18,066	12
13	Barber and Beauty Care	45,190	13
14	Non-Patient Meals	30,446	14
15	Telephone, Television and Radio	9,808	15
16	Rental of Facility Space	106,818	16
17	Sale of Drugs	322,637	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	85,939	19
20	Radiology and X-Ray	14,995	20
21	Other Medical Services	276,364	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 910,263	23
	D. Non-Operating Revenue		
24	Contributions	1,438,126	24
25	Interest and Other Investment Income***	(317,085)	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,121,041	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	See Supplemental Schedule	306,437	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 306,437	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 17,286,218	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,957,427	31
32	Health Care	8,570,283	32
33	General Administration	4,216,713	33
	B. Capital Expense		
34	Ownership	801,630	34
	C. Ancillary Expense		
35	Special Cost Centers	1,247,083	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 17,793,136	40
41	**Income before Income Taxes (line 30 minus line 40)****	(506,918)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (506,918)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,193,306	44
45	Private Pay - Net Inpatient Revenue	5,871,319	45
46	Medicare - Net Inpatient Revenue	342,000	46
47	Other-(specify) Insuance	24,373	47
48	Other-(specify)	3,605,295	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 13,036,293	49

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

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

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

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

Facility Name & ID Number St. Patrick's Residence # 0035006 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	1,968	2,312	$ 108,256	$ 46.82	1
2	Assistant Director of Nursing	1,130	1,234	50,771	41.14	2
3	Registered Nurses	69,777	80,389	2,615,715	32.54	3
4	Licensed Practical Nurses	24,930	29,414	812,566	27.63	4
5	CNAs & Orderlies	116,076	133,401	1,978,858	14.83	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,714	7,672	109,463	14.27	8
9	Activity Director	1,860	2,232	57,269	25.66	9
10	Activity Assistants	12,875	14,463	198,315	13.71	10
11	Social Service Workers	6,022	6,728	133,187	19.80	11
12	Dietician	1,637	1,859	52,302	28.13	12
13	Food Service Supervisor	3,768	4,424	125,001	28.26	13
14	Head Cook					14
15	Cook Helpers/Assistants	44,702	52,063	619,228	11.89	15
16	Dishwashers					16
17	Maintenance Workers	14,402	16,585	321,664	19.39	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,864	2,152	115,811	53.82	20
21	Assistant Administrator					21
22	Other Administrative	24,736	28,043	625,379	22.30	22
23	Office Manager					23
24	Clerical	7,177	8,613	242,953	28.21	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	339,638	391,584	$ 8,166,738 *	$ 20.86	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	120	25,663	10-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		13,689	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	12	760	11-3	44
45	Social Service Consultant				45
46	Other(specify) Revenue Cycle	4	783	21-3	46
47	Professional Consulting		1,500	19-3	47
48					48
49	TOTAL (lines 35 - 48)	136	$ 42,395		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	849	$ 64,805	10-3	50
51	Licensed Practical Nurses	5,566	255,126	10-3	51
52	Certified Nurse Assistants/Aides	32,451	747,915	10-3	52
53	TOTAL (lines 50 - 52)	38,866	$ 1,067,846		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Marilyn Daley	Administrator	0	$ 115,811
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 115,811

B. Administrative - Other

Description	Amount
Carmelite System Dues	$ 177,156
TOTAL (agree to Schedule V, line 17, col. 3)	$ 177,156
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Nixon Peabody	Legal	$ 17,241
Leading Age	Legal	1,000
CLA	Accounting/Audit	21,346
Practical System Solutions	Consulting	1,500
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 41,087

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 215,704
Unemployment Compensation Insurance	17,516
FICA Taxes	608,816
Employee Health Insurance	1,007,619
Employee Meals	61,816
Illinois Municipal Retirement Fund (IMRF)*	90,253
Life Insurance	38,863
Staff Development	15,323
Gifts and Events	20,637
Parking and Auto	90
Onboarding and Uniforms	7,210
EAP	3,671
TOTAL (agree to Schedule V, line 22, col.8)	$ 2,087,518

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	$ 0
Advertising: Employee Recruitment	14,083
Health Care Worker Background Check	1,649
(Indicate # of checks performed 165)	
Patient Background Checks 724	7,240
Dues/Subsriptions/License	44,584
Advertising	30,344
Less: Public Relations Expense	(36,550)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 61,350

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 12,522
In-State Travel	
Seminar Expense	5,187
Non-allowable adjustment Pg. 5a	(17,709)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

**See instructions.

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Leading Age $17,237**

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

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **97,072** Line **10**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **479,180**
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. $ **No** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **30,446**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

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

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

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