		FOR BHF USE			

LL1

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

2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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
  - [X] Charitable Corp.
  - [ ] Trust
- IRS Exemption Code ______
- [ ] PROPRIETARY
  - [ ] Individual
  - [ ] Partnership
  - [ ] Corporation
  - [ ] "Sub-S" Corp.
  - [ ] Limited Liability Co.
  - [ ] Trust
  - [ ] Other ______
- [ ] GOVERNMENTAL
  - [ ] State
  - [ ] County
  - [ ] 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 7/1/19 to 6/30/20 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)	Teri Taylor Director
	(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: 7/1/19 Ending: 6/30/20

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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	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	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	31,641			31,641	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	31,641			31,641	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.56%

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.

Facility Name & ID Number Brother James Court # 0020495 Report Period Beginning: 7/1/19 Ending: 6/30/20

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	217,944	32,373	10,800	261,117		261,117	0	261,117			1
2	Food Purchase		242,217		242,217		242,217	0	242,217			2
3	Housekeeping	54,304	33,341		87,645		87,645	0	87,645			3
4	Laundry	51,949	10,474		62,423	0	62,423	0	62,423			4
5	Heat and Other Utilities			163,863	163,863		163,863	0	163,863			5
6	Maintenance	88,196	254	108,979	197,429		197,429	0	197,429			6
7	Other (specify):*				0		0	0	0			7
8	**TOTAL General Services**	412,393	318,659	283,642	1,014,694	0	1,014,694	0	1,014,694			8
	B. Health Care and Programs											
9	Medical Director				0		0	0	0			9
10	Nursing and Medical Records	1,611,764	104,087	36,000	1,751,851		1,751,851	0	1,751,851			10
10a	Therapy			11,000	11,000		11,000	0	11,000			10a
11	Activities	37,904			37,904		37,904	0	37,904			11
12	Social Services	154,627	1,409	7,200	163,236		163,236	0	163,236			12
13	CNA Training				0		0	0	0			13
14	Program Transportation				0		0	0	0			14
15	Other (specify):* Pharmicist & Dietary			5,237	5,237		5,237	0	5,237			15
16	**TOTAL Health Care and Programs**	1,804,295	105,496	59,437	1,969,228	0	1,969,228	0	1,969,228			16
	C. General Administration											
17	Administrative	79,829			79,829		79,829	(79,829)	0			17
18	Directors Fees				0		0	0	0			18
19	Professional Services			123,485	123,485		123,485	0	123,485			19
20	Dues, Fees, Subscriptions & Promotions			34,730	34,730		34,730	0	34,730			20
21	Clerical & General Office Expenses	248,648	76,262	231,089	555,999		555,999	(3,500)	552,499			21
22	Employee Benefits & Payroll Taxes			323,967	323,967		323,967	0	323,967			22
23	Inservice Training & Education				0		0	0	0			23
24	Travel and Seminar				0		0	0	0			24
25	Other Admin. Staff Transportation				0		0	0	0			25
26	Insurance-Prop.Liab.Malpractice			58,577	58,577		58,577	0	58,577			26
27	Other (specify):*				0		0	0	0			27
28	**TOTAL General Administration**	328,477	76,262	771,848	1,176,587	0	1,176,587	(83,329)	1,093,258			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,545,165	500,417	1,114,927	4,160,509	0	4,160,509	(83,329)	4,077,180			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:** 7/1/19 **Ending:** 6/30/20

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			158,778	158,778		158,778	114,810	273,588			30
31	Amortization of Pre-Op. & Org.				0		0	0	0			31
32	Interest				0		0	0	0			32
33	Real Estate Taxes				0		0	0	0			33
34	Rent-Facility & Grounds			310,572	310,572		310,572	(310,500)	72			34
35	Rent-Equipment & Vehicles				0		0	0	0			35
36	Other (specify):*				0		0	0	0			36
37	TOTAL Ownership			469,350	469,350	0	469,350	(195,690)	273,660			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers				0		0	0	0			39
40	Barber and Beauty Shops				0		0	0	0			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee			236,880	236,880		236,880	0	236,880			42
43	Other (specify):*				0		0	0	0			43
44	TOTAL Special Cost Centers	0	0	236,880	236,880	0	236,880	0	236,880			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,545,165	500,417	1,821,157	4,866,739	0	4,866,739	(279,019)	4,587,720			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: 7/1/19 Ending: 6/30/20

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	(3,500)	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	(79,829)	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)**	$ (83,329)		$ 0	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)**	$ 0		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (83,329)		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

STATE OF ILLINOIS

Brother James Court

ID# 0020495

Report Period Beginning: 7/1/19

Ending: 6/30/20

	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: 7/1/19 Ending: 6/30/20

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	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	(79,829)	0	0	0	0	0	0	0	0	0	0	(79,829)	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	(3,500)	0	0	0	0	0	0	0	0	0	0	(3,500)	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**	(83,329)	0	0	0	0	0	0	0	0	0	0	(83,329)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(83,329)	0	0	0	0	0	0	0	0	0	0	(83,329)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Brother James Court # 0020495 Report Period Beginning: 7/1/19 Ending: 6/30/20

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

	Capital Expense D. Ownership	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)	
30	Depreciation	0	114,810	0	0	0	0	0	0	0	0	0	114,810	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	(195,690)	0	0	0	0	0	0	0	0	0	(195,690)	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)	(83,329)	(195,690)	0	0	0	0	0	0	0	0	0	(279,019)	45

Facility Name & ID Number Brother James Court # 0020495 Report Period Beginning: 7/1/19 Ending: 6/30/20

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

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	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%	114,810	114,810	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			$ 114,810	$ * (195,690)	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: 7/1/19 Ending: 6/30/20

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: 7/1/19 Ending: 6/30/20

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	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column 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								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: 7/1/19 Ending: 6/30/20

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]

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

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

	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: 7/1/19 Ending: 6/30/20

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	9/2/19			9/2/20	4.2500	1,180	6
7												7
8												8
9	TOTAL Facility Related						$ 0	$ 0			$ 1,180	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$ 0	$ 0			$ 0	14
15	TOTALS (line 9+line14)						$ 0	$ 0			$ 1,180	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: 7/1/19 Ending: 6/30/20

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2019 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).	$	0	3
4. Real Estate Tax accrual used for 2020 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.	$	0	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2015		8
	2016		9
	2017		10
	2018		11
	2019		12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2019	$	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.

2019 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 2019 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 2019.

	(A)	(B)	(C)	(D)
	Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 0.00	$ 0.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? ________ YES ________ 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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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: 7/1/19 Ending: 6/30/20

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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				$	1
2					2
3	TOTALS			$ 0	3

Facility Name & ID Number Brother James Court # 0020495 Report Period Beginning: 7/1/19 Ending: 6/30/20

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			1996	1996	$ 1,251,493	$	30	$ 41,716	$ 41,716	$ 980,336	4
5			1975	1975	1,003,250		30	0		1,003,250	5
6			1997	1997	1,256,490		30	41,883	41,883	926,075	6
7											7
8											8
	Improvement Type**										
9	BJC - NEW WING CHANGE ORDERS			1997	18,883		30	629	629	14,215	9
10	BJC REPAVING PARKING LOT			1986	42,236		10			42,236	10
11	BJC BLDG IMPROVEMENTS			1980	16,233		11			16,233	11
12	BJC BLDG IMPROVEMENTS			1984	21,419		10			21,419	12
13	BJC VARIOUS			1987	69,555		10			69,555	13
14	INSULATION			1991	9,175		15			9,175	14
15	TANK REMOVAL			1992	8,500		10			8,500	15
16	BJC - STEAM LINE			1985	14,479		10			14,479	16
17	BJC - BLDG IMPROVEMENTS			1975	19,600		24			19,600	17
18	BJC - SIDEWALK/PATIO			1976	3,545		10			3,545	18
19	BJC BIKE RINK			1978	2,500		5			2,500	19
20	BJC SITE IMPROVEMENT			1979	1,440		26			1,440	20
21	BJC ROOF			1979	12,166		10			12,166	21
22	BJC VARIOUS DONATED			1988	46,656		10			46,656	22
23	BJC WATER LINE			1989	3,166		20			3,166	23
24	SEWAGE TREATMENT PLANT			1990	6,411		20			6,411	24
25	TANK REMOVAL			1991	9,810		10			9,809	25
26	PARKING LOT			1992	10,453		10			10,453	26
27	REPAVING PARKING LOT			1994	850		10			850	27
28	PUMP			1994	734		10			734	28
29	BJC LAND IMP - TREES			1996	3,470		20			3,470	29
30	BJC - IMPROVEMENTS			1998	15,712		30	524	524	11,435	30
31	WATER LINE REPAIR			1999	3,102		10			3,102	31
32	BJC LAND IMP - TREES			1999	25,849		20	862	862	25,849	32
33	GATE			1999	550		5			550	33
34	BJC			1999	5,773		10			5,773	34
35	FLOOR			2000	1,683		7			1,683	35
36	BJC OFFICE DOOR WINDOWS			2010	1,092		15	72	72	692	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: 7/1/19 Ending: 6/30/20

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	ROOF - LAUNDRY BLDG	2011	$ 6,493	$	10	$ 649	$ 649	$ 5,249	37
38	LIGHT FIXTURES FOR BJC BUILDING	2011	1,322		10	132	132	1,079	38
39	GENERATOR ENGINEERING SERVICES	2019	8,535		10	569	569	569	39
40	GENERATOR PROJECT	2019	125,440		10	8,362	8,362	8,363	40
41	WINDOWS	2018	3,307		10	330	330	468	41
42	WATER HEATER	2018	13,000		10	1,300	1,300	1,517	42
43	HOT WATER SYSTEM	2018	4,697		10	469	469	509	43
44	MECHANICAL BUILDING ADDITION	2019	136,357		10	11,363	11,363	11,363	44
45	EMERGENCY GENERATOR	2019	9,900		10	660	660	660	45
46	EMERGENCY GENERATOR	2019	18,239		10	1,215	1,215	1,216	46
47	BOILER ROOM PROJECT	1994	170,330		20			170,330	47
48	TOTAL LIFE CENTER 2	1998	122,261		30	4,075	4,075	87,960	48
49	BOILER ROOM REMODELING	1992	12,498		20			12,498	49
50	BOILER ROOM CONSULTING	1993	15,106		20			15,106	50
51	BJC WATER LINE	1987	14,120		20			14,120	51
52	BJC HALL REMODEL	2019	93,916		10	0		0	52
53	LEASEHOLD IMPROVEMENTS	1985	15,200		10			15,200	53
54	LEASEHOLD IMPROVEMENTS	1986	19,507		3			19,507	54
55	PAINTING	1987	9,922		10			9,922	55
56	STEEL DOOR	1987	6,020		10			6,020	56
57	CORRIDOR WINDOW REMOVAL	1987	2,013	0	10			2,013	57
58	EMERGENCY GEN. SWITCH	1988	3,335	0	30			3,335	58
59	REMODEL LOBBY	1989	156,996	2,180	10	2,180		156,996	59
60	TRANSFER SWITCH	1989	1,127	0	10			1,127	60
61	HEAT-ENERGY PANEL	1989	8,633	0	10			8,633	61
62	ROOF REPAIR	1990	6,928	0	30			6,928	62
63	REMODELING	1990	6,953	193	10	193		6,953	63
64	OVERHEAD DOOR	1990	1,220		10			1,220	64
65	KITCHEN TANKS	1990	3,089		10			3,089	65
66	NEW PLASTER	1990	1,649		10			1,649	66
67	PLASTERING	1990	937		10			937	67
68	REMODEL CEILING	1990	2,970		10			2,970	68
69	OFFICE SIGNS	1990	170		10			170	69
70	TOTAL (lines 4 thru 69)		$ 4,888,465	$ 2,373		$ 117,183	$ 114,810	$ 3,853,033	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: 7/1/19 Ending: 6/30/20

XI. OWNERSHIP COSTS (continued)

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

	1	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 4,888,465	$ 2,373		$ 117,183	$ 114,810	$ 3,853,033	1
2	ROOF REPAIR	1990	2,200		10			2,200	2
3	LEASEHOLD IMPROVEMENT	1990	8,762		10			8,762	3
4	LEASEHOLD IMPROVEMENT	1990	11,633		10			11,633	4
5	LEASEHOLD IMPROVEMENT	1990	3,250		10			3,250	5
6	INSTALLATION OF TILE	1991	876		10			876	6
7	CAFETERIA DOORS	1993	11,918		10			11,918	7
8	PLUMBING WORK	1994	6,858		10			6,858	8
9	DOOR	1996	656		10			656	9
10	FURNACE	1996	502		10			502	10
11	GRIP CAPS	1996	1,575		5			1,575	11
12	AIR DEFLECTORS	1996	381		3			381	12
13	SHOWER	1996	259		5			259	13
14	FLOOR COVERINGS	1997	1,722		10			1,722	14
15	REDECORATE SNACK LOUNGE & AN OFFICE	1999	2,847		5			2,847	15
16	ROOF REPAIRS	1999	846		10			846	16
17	CARPET IN FRONT OFFICE	1999	8,881		5			8,881	17
18	YARD SIGNS	1999	2,825		10			2,825	18
19	VINYL WALL COVERING	1999	1,127		10			1,127	19
20	SHOWER ROOM REPAIRS	1999	8,220		10			8,220	20
21	CONDENSER	1999	12,396		10			12,396	21
22	DROP ROD ASSEMBLY	1999	6,408		10			6,408	22
23	FENCING	1999	3,840		10			3,840	23
24	TREES	1999	9,905		10			9,905	24
25	ROOF REPAIRS	2000	2,300		10			2,300	25
26	TILE FLOOR - RESIDENT WINGS	2000	34,740		10			34,740	26
27	CLEAR GLASS FOR WINDOWS (10)	2000	2,009		10			2,009	27
28	CABINET MODIFICATION	1999	4,520		7			4,520	28
29	HOLY CROSS - ELECTRICAL	1999	17,410		15			17,410	29
30	HOLY CROSS - SIGN	1999	900		5			900	30
31	HOLY CROSS - MASONRY	1999	23,465		15			23,465	31
32	HOLY CROSS - PLUMBING/HEATING	1999	31,000		15			31,000	32
33	HOLY CROSS - REMODELING	1999	19,524		15			19,524	33
34	TOTAL (lines 1 thru 33)		$ 5,132,220	$ 2,373		$ 117,183	$ 114,810	$ 4,096,788	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: 7/1/19 Ending: 6/30/20

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		$ 5,132,220	$ 2,373		$ 117,183	$ 114,810	$ 4,096,788	1
2	PAINTING CEILING OF BASEMENT	2000	664		5			664	2
3	RAMP AREA DECORATING	2001	14,387		5			14,387	3
4	RECEPTABLES - BEDROOMS	2001	9,820		5			9,820	4
5	SHOWER ROOM FLOOR REPAIR	2002	1,123		10			1,123	5
6	BOILER	2002	3,960		5			3,960	6
7	REPAVE SIDEWALKS	2002	810		10			810	7
8	TUCKPOINTING	2002	1,490		10			1,490	8
9	FLOORS - WING 500	2002	2,688		10			2,688	9
10	TRILOGY KEYPAD LOCK	2002	580		10			580	10
11	HOT WATER STORAGE TANK - LAUNDRY	2002	4,409		10			4,409	11
12	DOORS & FRAMES	2003	3,733		10			3,733	12
13	POLE LIGHTING - WEST PARKING LOT	2003	3,740		15			3,740	13
14	SINK FAUCET & CABINET	2004	1,133		7			1,133	14
15	DOORS	2004	4,987		15			4,987	15
16	CEILING FAN	2004	1,082		7			1,082	16
17	ELECTRIC WORK	2004	16,000		15			16,000	17
18	ALARM SYSTEM	2004	2,204		7			2,204	18
19	PARKING LOT	2004	3,443		10			3,443	19
20	BOILER - KITCHEN STEAMER	2004	4,871		7			4,871	20
21	BOILER	2004	6,900		7			6,900	21
22	BOILER	2004	7,200		7			7,200	22
23	HVAC LABOR AND MATERIAL FOR 2ND FLOOR	2004	12,497		7			12,497	23
24	PARKING LOT	2004	74,847	2,495	30	2,495		39,711	24
25	DENTIST'S OFFICE RENOVATION	2004	57,955	1,932	30	1,932		30,427	25
26	POLE LIGHT REPLACEMENT	2004	1,868		7			1,868	26
27	STORAGE ROOM	2004	2,375		7			2,375	27
28	ALARM FOR BUILDING	2005	3,000		10			3,000	28
29	ALARM FOR BUILDING	2005	3,041		10			3,041	29
30	ROOF	2005	22,370	1,119	20	1,119		16,311	30
31	WATER HEATER	2006	32,250		10			32,250	31
32	BOILER	2006	4,611		7			4,611	32
33	GENERATOR	2006	2,814		5			2,814	33
34	TOTAL (lines 1 thru 33)		$ 5,445,072	$ 7,919		$ 122,729	$ 114,810	$ 4,340,917	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: 7/1/19 Ending: 6/30/20

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		$ 5,445,072	$ 7,919		$ 122,729	$ 114,810	$ 4,340,917	1
2	ALARM FOR BUILDING	2007	3,325		10			3,325	2
3	NEW ROOF	2007	90,882	3,029	30	3,029		39,130	3
4	EXTERIOR FLOOD LIGHT	2007	945		10			945	4
5	NEW WATER HEATER	2008	71,300		10			71,300	5
6	A/C UNIT - NURSING STATION, BREAK ROOM	2009	7,934		10			7,934	6
7	ALARM SYSTEM UPGRADES	2009	1,240		10			1,240	7
8	POWER SUPPLY FOR NEW A/C UNIT	2009	1,443		3			1,443	8
9	PROF FEES - NEW HOT WATER SYSTEM	2008	5,600		7			5,600	9
10	A/C ROOFTOP UNIT	2009	27,544		10			27,544	10
11	BATHROOM RENOVATION	2009	3,346		7			3,346	11
12	SEAL & STRIPE PARKING LOT	2009	3,315		7			3,315	12
13	REPAVING TRACK	2009	8,400		7			8,400	13
14	WING 300 BATHROOM RENOVATION	2009	44,169		7			44,169	14
15	REPAVE WALKING PATH	2009	1,450		7			1,450	15
16	REPAIR BRICK ON GARAGE	2009	12,330	308	10	308		12,330	16
17	REPLACE HOT & CHILLED WATER PIPING W400	2009	12,968		7			12,968	17
18	SEWER STATION CONSTRUCTION OF TRASH RACK	2009	15,375		7			15,375	18
19	EXTENDING MAINS TO GOOD PIPE W200	2009	2,787		7			2,787	19
20	REPAIR BOILER ROOM ROOF	2010	15,462	515	30	515		5,283	20
21	LIGHT FIXTURES FOR FRONT ENTRANCE	2010	4,791		5			4,791	21
22	WATER HEATER	2011	16,761	1,676	10	1,676		15,225	22
23	ROOF REPAIRS	2011	6,804	680	10	680		6,124	23
24	SEWER GRINDER	2010	23,908	2,391	10	2,391		23,310	24
25	ROOF	2010	19,800	990	20	990		9,735	25
26	BATHROOM TILE	2010	1,200	120	10	120		1,140	26
27	CABINETS	2011	1,867		5			1,867	27
28	SIDEWALK	2010	4,169	417	10	417		4,064	28
29	DRAIN	2010	3,611	361	10	361		3,611	29
30	OUTSIDE LIGHTING	2010	4,184		5			4,184	30
31	DOORS	2010	4,169	417	10	417		4,134	31
32	FRONT SIDEWALK	2010	8,850	885	10	885		8,703	32
33	FRONT DOOR OPERATORS	2010	11,541	1,154	10	1,154		11,349	33
34	TOTAL (lines 1 thru 33)		$ 5,886,542	$ 20,862		$ 135,672	$ 114,810	$ 4,707,038	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: 7/1/19 Ending: 6/30/20

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		$ 5,886,542	$ 20,862		$ 135,672	$ 114,810	$ 4,707,038	1
2	FRONT DOOR ELECTRIC	2010	2,119	212	10	212		2,066	2
3	SEALCOAT PARKING LOT	2011	3,500	233	15	233		2,080	3
4	GARAGE DOOR	2011	6,577	329	20	329		2,932	4
5	CONCRETE	2011	4,465	298	15	298		2,630	5
6	HOSE AND CART	2011	113	11	10	11		100	6
7	SIDEWALK	2011	8,250	825	10	825		7,287	7
8	GARAGE WINDOW	2011	6,875	688	10	688		6,015	8
9	KITCHEN CABINETS	2011	3,980	398	10	398		3,449	9
10	COUNTERTOPS, FORMICA	2011	1,120	56	20	56		485	10
11	ALARM VIDEO	2012	5,998	600	10	600		4,998	11
12	DOUBLE DOORS	2012	2,552	170	15	170		1,418	12
13	DRAPERY	2012	2,564	256	10	256		2,115	13
14	CURTAIN ROD	2012	96	10	10	10		79	14
15	WINDOW (PLANT SERVICE BUILDING)	2012	15,208	1,521	10	1,521		12,166	15
16	TILE REMOVAL	2012	5,260	526	10	526		4,120	16
17	FLOOR TILE	2012	4,200	420	10	420		3,290	17
18	HEAT EXCHANGER	2012	15,664	1,044	15	1,044		8,093	18
19	FIRE SPRINKLER	2012	44,209		5			44,209	19
20	FIRE ALARM SYSTEM	2013	40,199		5			40,199	20
21	FIRE ALARM GARAGE	2013	5,374		5			5,374	21
22	SURVEILLANCE CAMERAS	2013	10,135	1,448	7	1,448		10,135	22
23	VIDEO CAMERAS	2013	5,040	720	7	720		5,040	23
24	TANK SUMP PUMP LID	2013	4,396	440	10	440		3,040	24
25	HORIZONTAL BOILDER FEED WATER	2013	15,670	2,239	7	2,239		14,924	25
26	FIRE ALARM PLAN SERVICE/GARAGE	2013	9,133		5			9,133	26
27	PARKING LOT LIGHTING	2014	5,380	359	15	359		2,122	27
28	B&G ELECTRIC PUMP	2014	644	43	15	43		254	28
29	NURSE DOOR ALARM	2015	13,343	890	15	890		4,744	29
30	DOOR ALARM	2015	11,764	784	15	784		4,117	30
31	DOOR ALARM	2015	17,837	1,189	15	1,189		6,144	31
32	OFFICE CARPET	2015	3,340	334	10	334		1,809	32
33	TV WALL MOUNT	2015	448	64	7	64		346	33
34	TOTAL (lines 1 thru 33)		$ 6,161,995	$ 36,969		$ 151,779	$ 114,810	$ 4,921,951	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: 7/1/19 Ending: 6/30/20

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		$ 6,161,995	$ 36,969		$ 151,779	$ 114,810	$ 4,921,951	1
2	LIGHT FIXTURE	2015	1,142	163	7	163		843	2
3	LIGHTING	2015	10,670	1,524	7	1,524		7,748	3
4	A/C DOCTORS OFFICE	2015	5,468	547	10	547		2,688	4
5	WIRING PHONE FIBER OPTICS	2015	1,159	166	7	166		800	5
6	A/C ELECTRICAL ROOM	2015	5,376	538	10	538		2,598	6
7	HEATING VALVES	2015	2,558	365	7	365		1,705	7
8	SECURITY CAMERAS	2016	2,975	425	7	425		1,877	8
9	BOILER CONTACTOR PUMP 1	2016	422	60	7	60		271	9
10	BOILER CONTRACTOR PUMP 2	2016	422	60	7	60		271	10
11	CHILLER	2017	80,673	8,067	10	8,067		26,891	11
12	LANDSCAPING	2017	8,595	860	10	860		2,722	12
13	ACCESS CONTROL	2017	2,989	299	10	299		947	13
14	PARKING LOT LIGHTS	2016	4,960	496	10	496		1,736	14
15	COMPRESSOR	2016	6,081	608	10	608		2,230	15
16	DOOR	2017	1,914	191	10	191		574	16
17	NEW AC UNITS	2017	2,112	106	20	106		290	17
18	FIRESTOP ABOVE WING 200 DOORS	2017	4,175	209	20	209		522	18
19	WATER SEPERATOR FOR CHILLED WATER	2018	6,041	302	20	302		629	19
20	MAGLOCK ON FRONT DOOR	2017	2,733	547	5	547		1,548	20
21	WINDOW REFLECTIVE EXTERIOR FILM	2018	1,404		1			1,404	21
22	ATRIUM HVAC REPAIRS	2018	6,612	661	10	661		1,102	22
23	SEWER PUMPS	2018	2,332	233	10	233		408	23
24	WING 200 EXIT BAR	2019	1,547	155	10	155		232	24
25	WING 200/300 DOOR OPENER (2)	2019	3,728	373	10	373		466	25
26	PUMP REBUILD (BNG 1535)	2019	1,279	256	5	256		320	26
27	WALK-IN FREEZER EQUIPMENT	2019	7,860	1,572	5	1,572		1,835	27
28	WATER HEATERS	2019	107,350	10,735	10	10,735		14,313	28
29	WATER HEATER INSULATION	2019	10,500	1,050	10	1,050		1,400	29
30	RETUBE 2 BOILERS	2019	21,800	2,855	7	2,855		2,855	30
31	FREEDOM STEEL BUILDINGS DEPOSIT	2019	4,683	182	15	182		182	31
32	FREEDOM STEEL PAVILION	2019	15,352	512	15	512		512	32
33	STORAGE TANK-LAUNDRY AREA	2020	4,944	206	10	206		206	33
34	TOTAL (lines 1 thru 33)		$ 6,501,851	$ 71,292		$ 186,102	$ 114,810	$ 5,004,076	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: 7/1/19 Ending: 6/30/20

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		$ 6,501,851	$ 71,292		$ 186,102	$ 114,810	$ 5,004,076	1
2	TANKLESS WATER HEATER-MAIN HALLWAY	2020	29,645	1,235	10	1,235		1,235	2
3	NEW HANDWASHING SINK	2020	3,376		7			0	3
4	30% DOWN COCHRAN CONSTRUCTION	2019	23,472	913	15	913		913	4
5	ALARMS/SMOKE DETECTOR	1998	20,108		5			20,108	5
6	BOILER	1996	3,335		10			3,335	6
7	DOOR REPAIRS	2002	6,197		10			6,197	7
8	NET DRAPERIES	2001	0		5			0	8
9	FLOOR	1997	2,658		8			2,658	9
10	NET LAND IMPROVEMENTS	1996	660		3			660	10
11	LANDSCAPING	1999	18,255		10			18,255	11
12	LEASEHOLD IMPROVEMENTS 3		5,754		5			5,754	12
13	LEASEHOLD IMPROVEMENTS	1999	2,597		5			2,597	13
14	NET LEASHOLD IMP		1,158		10			1,158	14
15	NET NEW TEES & VALVES	1999	10,412		10			10,412	15
16	NET PAINTING	1995			10				16
17	NET PAINTING	2000			10				17
18	NET PARKING LOT SECURITY SYST		16,029		7			16,029	18
19	NET REPAIRS	1996	6,704		10			6,704	19
20	ROOF REPAIR	1996	5,985		10			5,985	20
21	SEWER	1996	9,387		10			9,387	21
22	STRIP/REFINISH FLOORS	2002	8,702		10			8,702	22
23	TOILET ROOM ADDITION/RENO		699,826	23,328	30	23,328		385,618	23
24	BUS STOP	2020	1,396	70	5	70		70	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)		$ 7,377,507	$ 96,838		$ 211,648	$ 114,810	$ 5,509,853	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: 7/1/19 Ending: 6/30/20

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 12G, Carried Forward		$ 7,377,507	$ 96,838		$ 211,648	$ 114,810	$ 5,509,853	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
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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)		$ 7,377,507	$ 96,838		$ 211,648	$ 114,810	$ 5,509,853	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: 7/1/19 Ending: 6/30/20

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	$ 390,476	$ 53,735	$ 53,735	$ 0	various	$ 242,587	71
72	Current Year Purchases	21,159	753	753	0	various	753	72
73	Fully Depreciated Assets	1,412,238	0		0	various	1,412,238	73
74					0			74
75	TOTALS	$ 1,823,873	$ 54,488	$ 54,488	$ 0		$ 1,655,578	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	$	$	$ 0	5	$ 9,500	76
77	Resident Transportation	Van	Various	61,875	5,700	5,700	0	5	46,675	77
78	Resident Transportation	Auto - Fully Depreciated	Various	136,680			0	5	136,680	78
79	Resident Transportation	Car and Cart	Various	17,006	1,754	1,754	0	5	14,521	79
80	TOTALS			$ 225,061	$ 7,454	$ 7,454	$ 0		$ 207,376	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)	$ 9,426,441	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 158,780	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 273,590	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 114,810	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 7,372,807	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.

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 2023

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

	Fiscal Year Ending	Annual Rent
12.	/2021	$ 310,500
13.	/2022	$ 310,500
14.	/2023	$ 310,500

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: 7/1/19 Ending: 6/30/20

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 67

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$ 0
2	Books and Supplies		560		560
3	Classroom Wages (a)		5,626		5,626
4	Clinical Wages (b)		9,426		9,426
5	In-House Trainer Wages (c)		0		0
6	Transportation				0
7	Contractual Payments				0
8	CNA Competency Tests				0
9	TOTALS	$ 0	$ 15,612	$ 0	$ 15,612
10	SUM OF line 9, col. 1 and 2 (e)	$ 15,612			

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	14
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	14

(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.

Facility Name & ID Number Brother James Court # 0020495 Report Period Beginning: 7/1/19 Ending: 6/30/20

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
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.

Facility Name & ID Number Brother James Court # 0020495 Report Period Beginning: 7/1/19 Ending: 6/30/20

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 6/30/20 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,242,434	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	469,246		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	110,218		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	41,220		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,863,118	$ 0	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	2,322,220		12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	2,744,723		15
16	Equipment, at Historical Cost	2,048,934		16
17	Accumulated Depreciation (book methods)	(3,766,450)		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)**	$ 3,349,427	$ 0	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,212,545	$ 0	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,208,929	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	124,346		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 Pension	20,277		36
37	Accrued Vacation	95,359		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,448,911	$ 0	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)**	$ 0	$ 0	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,448,911	$ 0	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,763,634	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,212,545	$ 0	48

*(See instructions.)

Facility Name & ID Number Brother James Court # 0020495 Report Period Beginning: 7/1/19 Ending: 6/30/20

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,871,410	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,871,410	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(107,776)	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)**	$ (107,776)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 0	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 3,763,634	24 *

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

Facility Name & ID Number Brother James Court # 0020495 Report Period Beginning: 7/1/19 Ending: 6/30/20

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	$ 4,462,917	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,462,917	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)**	$ 0	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	25,794	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	10,150	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 35,944	23
	D. Non-Operating Revenue		
24	Contributions	192,950	24
25	Interest and Other Investment Income***	34,929	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 227,879	26
	E. Other Revenue (specify):****		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	Misc Income	32,223	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 32,223	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,758,963	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,014,694	31
32	Health Care	1,969,228	32
33	General Administration	1,176,587	33
	B. Capital Expense		
34	Ownership	469,350	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	236,880	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,866,739	40
41	**Income before Income Taxes (line 30 minus line 40)****	(107,776)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (107,776)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,727,518	44
45	Private Pay - Net Inpatient Revenue	0	45
46	Medicare - Net Inpatient Revenue	0	46
47	Other-(specify) Social Security	698,316	47
48	Other-(specify) Third Party Payments	37,083	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,462,917	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: 7/1/19 Ending: 6/30/20

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,680	1,680	$ 56,868	$ 33.85	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,554	3,554	101,032	28.43	3
4	Licensed Practical Nurses	18,728	18,728	424,989	22.69	4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	3,003	3,003	37,904	12.62	9
10	Activity Assistants					10
11	Social Service Workers	1,296	1,296	25,781	19.89	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	38,216	18.37	13
14	Head Cook					14
15	Cook Helpers/Assistants	17,547	17,547	179,728	10.24	15
16	Dishwashers					16
17	Maintenance Workers	4,997	4,997	88,196	17.65	17
18	Housekeepers	5,240	5,240	54,304	10.36	18
19	Laundry	4,172	4,172	51,949	12.45	19
20	Administrator	2,084	2,084	79,829	38.31	20
21	Assistant Administrator					21
22	Other Administrative	13,252	13,252	248,648	18.76	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)	7,203	7,203	128,846	17.89	28
29	Resident Services Coordinator	2,033	2,033	62,675	30.83	29
30	Habilitation Aides (DD Homes)	86,480	86,480	934,828	10.81	30
31	Medical Records	2,149	2,149	31,372	14.60	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	175,498	175,498	$ 2,545,165 *	$ 14.50	34

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

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	various	$ 10,800	1, 3	35
36	Medical Director				36
37	Medical Records Consultant	various	36,000	10, 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	various	5,237	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	Psycologist Consultant	various	11,000	10a, 3	47
48					48
49	TOTAL (lines 35 - 48)		$ 70,237		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	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: 7/1/19 Ending: 6/30/20

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Sonia Bartles	Administrator	0	$ 79,829
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 79,829

B. Administrative - Other

Description	Amount
Accounting	$
Legal	
Trust Fees	
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/Acctg	$ 32,960
Legal	Legal	83,413
INB	Trust/Fiduciary Fees	2,571
Illinois Health Care Assoc	Advocacy	4,541
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 123,485

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 69,341
Unemployment Compensation Insurance	16,205
FICA Taxes	191,223
Employee Health Insurance	
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	11,740
Continuing Education	1,702
Staff Recognition	20
401(k) Contribution	23,045
Life Insurance	10,691
TOTAL (agree to Schedule V, line 22, col.8)	$ 323,967

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	26,647
Health Care Worker Background Check	5,704
(Indicate # of checks performed)	
Patient Background Checks	
Dues and Subscriptions	2,379
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 34,730

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.

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. $ **236,880**
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. $ **10,150**
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 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.