FOR BHF USE

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

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: 0005637

Facility Name: St Joseph Nursing Home

Address: 401 9th Street (Number) Lacon (City) 61540 (Zip Code)

County: Marshall

Telephone Number: (309) 246-2175 **Fax #** (309) 246-2299

HFS ID Number:

Date of Initial License for Current Owners: 1964

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: Larry Templin **Telephone Number:** (630) 361-2868
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 7/1/18 to 6/30/19 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) Sister Loretta Matas
(Title) President

Paid Preparer

(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title) Larry Templin, Partner
(Firm Name & Address) Templin Healthcare Accounting Services, LLP, P.O. Box 326, Plainfield, IL 60544-0326
(Telephone) (630) 361-2868 Fax # ( )

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number St Joseph Nursing Home # 0005637 Report Period Beginning: 7/1/18 Ending: 6/30/19

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 N/A

	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	93	Skilled (SNF)	93	34,038	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	93	TOTALS	93	34,038	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			1,856	1,856	8
9	SNF/PED					9
10	ICF	14,616	9,483		24,099	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,616	9,483	1,856	25,955	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.25%

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)
Headstart and Sherriff's Department

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] Non-allowable costs have been eliminated in Schedule V, Column 7

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

I. On what date did you start providing long term care at this location?
Date started 5/7/1965

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 [X] NO [ ] If YES, enter number of beds certified 93 and days of care provided 1,856

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 6/30/20 Fiscal Year: 6/30/20

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number St Joseph Nursing Home # 0005637 Report Period Beginning: 7/1/18 Ending: 6/30/19

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	313,293	10,959	7,233	331,485		331,485		331,485			1
2	Food Purchase		245,475		245,475		245,475	(30,463)	215,012			2
3	Housekeeping	110,160	960		111,120		111,120		111,120			3
4	Laundry	61,319	1,670		62,989		62,989		62,989			4
5	Heat and Other Utilities			91,472	91,472		91,472	(3,382)	88,090			5
6	Maintenance	98,578	41,380	64,828	204,786		204,786	1,500	206,286			6
7	Other (specify):*											7
8	TOTAL General Services	583,350	300,444	163,533	1,047,327		1,047,327	(32,345)	1,014,982			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	1,937,073	146,971	8,770	2,092,814		2,092,814		2,092,814			10
10a	Therapy											10a
11	Activities	81,693	875	2,115	84,683		84,683		84,683			11
12	Social Services	1,720	332	3,842	5,894		5,894		5,894			12
13	CNA Training											13
14	Program Transportation			3,064	3,064		3,064		3,064			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,020,486	148,178	35,791	2,204,455		2,204,455		2,204,455			16
	C. General Administration											
17	Administrative	94,808		292,396	387,204		387,204		387,204			17
18	Directors Fees											18
19	Professional Services			79,076	79,076		79,076	(200)	78,876			19
20	Dues, Fees, Subscriptions & Promotions			7,842	7,842		7,842		7,842			20
21	Clerical & General Office Expenses	140,392	11,429	16,087	167,908		167,908	(5,988)	161,920			21
22	Employee Benefits & Payroll Taxes			614,771	614,771		614,771		614,771			22
23	Inservice Training & Education											23
24	Travel and Seminar			198	198		198		198			24
25	Other Admin. Staff Transportation			3,064	3,064		3,064		3,064			25
26	Insurance-Prop.Liab.Malpractice			57,908	57,908		57,908		57,908			26
27	Other (specify):*											27
28	TOTAL General Administration	235,200	11,429	1,071,342	1,317,971		1,317,971	(6,188)	1,311,783			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,839,036	460,051	1,270,666	4,569,753		4,569,753	(38,533)	4,531,220			29

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

SEE ACCOUNTANTS' PREPARATION REPORT

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 Joseph Nursing Home #0005637 Report Period Beginning: 7/1/18 Ending: 6/30/19

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			84,110	84,110		84,110	(147)	83,963			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			21,041	21,041		21,041	(11,835)	9,206			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			105,151	105,151		105,151	(11,982)	93,169			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			1,443	1,443		1,443		1,443			38
39	Ancillary Service Centers		87,783	355,590	443,373		443,373		443,373			39
40	Barber and Beauty Shops			10,246	10,246		10,246		10,246			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			197,777	197,777		197,777		197,777			42
43	Other (specify):* **Disallowed Costs**	52,723		179,551	232,274		232,274	(232,274)				43
44	**TOTAL Special Cost Centers**	52,723	87,783	744,607	885,113		885,113	(232,274)	652,839			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,891,759	547,834	2,120,424	5,560,017		5,560,017	(282,789)	5,277,228			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number St Joseph Nursing Home # 0005637 Report Period Beginning: 7/1/18 Ending: 6/30/19

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	(30,463)	2		4
5	Telephone, TV & Radio in Resident Rooms	(14,118)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(147)	30		9
10	Interest and Other Investment Income	(713)	32		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	(12,654)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(200)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(148,704)	43		24
25	Fund Raising, Advertising and Promotional	(4,075)	43		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 See Page 5A	(71,715)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (282,789)		$	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))**	$ (282,789)		37

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

St Joseph Nursing Home
ID# 0005637
Report Period Beginning: 7/1/18
Ending: 6/30/19

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Sisters' Portion of Heat and Other Utilities	$ (3,382)	5	1
2	Disallow Related Party Interest Expense	(11,122)	32	2
3	Disallow Marketing Wages	(52,723)	43	3
4	Offset Miscellaneous Income Against Office Supplies	(5,988)	21	4
5	Expensed Minor Capitalized Repair	1,500	6	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
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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**	(71,715)		49

Facility Name & ID Number St Joseph Nursing Home # 0005637 Report Period Beginning: 7/1/18 Ending: 6/30/19

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-Supp		None		None		

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 [X] 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			$			$	$ 0	1
2	V								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			$			$	$ *	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number St Joseph Nursing Home # 0005637 Report Period Beginning: 7/1/18 Ending: 6/30/19

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	Board of Directors							1
2	Sister Loretta Matas-President	0						2
3	Sister Michael Fox-Sec/Treasurer	0						3
4	Sister Miroslava Gelatikova	0						4
5	Sister Justina Delonga	0						5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
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16								16
17								17
18								18
19								19
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22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number St Joseph Nursing Home # 0005637 Report Period Beginning: 7/1/18 Ending: 6/30/19

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	Sister Michael Fox	Secretary/Treasurer	Administrative	0.00	None	1	3.40	N/A	$ None	N/A	1
2	Sister Miroslava Gelatikova	Board Member	Administrative	0.00	None	1	3.72	N/A	None	N/A	2
3	Sister Michael Fox	C.N.A	Nursing	0.00	None	32.88	96.60	Wages	15,927	L10,C1	3
4	Sister Miroslava Gelatikova	Activities Associate	Activities	0.00	None	25.85	96.28	Wages	13,379	L11,C1	4
5											5
6											6
7											7
8											8
9	Both Sisters listed above are employees of the facility as well as Board members.										9
10											10
11											11
12											12
13								TOTAL	$ 29,306		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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number St Joseph Nursing Home # 0005637 Report Period Beginning: 7/1/18 Ending: 6/30/19

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number St Joseph Nursing Home # 0005637 Report Period Beginning: 7/1/18 Ending: 6/30/19

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	1st National Bank of Lacon		X	Working Capital	$5,000.00	11/14/16	$ 400,000	$ 180,676	10/14/23	0.0475	$ 9,919	1
2	Sisters of St Francis of Assisi	X		Working Capital	Interest Only	9/1/16	791,000	1,061,406	09/01/23	1.2500	11,122	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$5,000.00		$ 1,191,000	$ 1,242,082			$ 21,041	9
	B. Non-Facility Related*											
10												10
11						Disallow Related Party Interest Expense					(11,122)	11
12						Offset Interest Income					(713)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (11,835)	14
15	TOTALS (line 9+line14)						$ 1,191,000	$ 1,242,082			$ 9,206	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None Line # N/A

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

SEE ACCOUNTANTS' PREPARATION REPORT

** 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 Joseph Nursing Home # 0005637 Report Period Beginning: 7/1/18 Ending: 6/30/19

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 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.)	2019	$	2
3. Under or (over) accrual (line 2 minus line 1).		$	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.		$	7

Real Estate Tax History:

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

This facility is exempt from paying real estate taxes.

	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.

SEE ACCOUNTANTS' PREPARATION REPORT

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME St Joseph Nursing Home COUNTY Marshall

FACILITY IDPH LICENSE NUMBER 0005637

CONTACT PERSON REGARDING THIS REPORT Sister Loretta Matas

TELEPHONE (309) 246-2175 FAX #: (309) 246-2299

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) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.	N/A		$	$
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 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 St Joseph Nursing Home # 0005637 Report Period Beginning: 7/1/18 Ending: 6/30/19

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 66,656 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

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).

None

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

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Patient Care	428,532	1965	$ 25,700	1
2					2
3	TOTALS	428,532		$ 25,700	3

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number St Joseph Nursing Home # 0005637 Report Period Beginning: 7/1/18 Ending: 6/30/19

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	43		1965	1965	$ 465,065	$	50	$	$	$ 465,065	4
5	50		1969	1969	898,293	17,966	50	17,966		898,293	5
6			1968	1968	395,224		25			395,224	6
7			1986	1986	9,717		12			9,717	7
8			2010	2010	5,818	388	15	388		4,267	8
	Improvement Type**										
9	Misc			1968	6,160		50			6,160	9
10	Garage			1972	2,491	50	50	50		2,392	10
11	Finish Basement			1973	6,343	127	50	127		5,963	11
12	Window			1974	900	18	50	18		828	12
13	Insulation			1976	21,986	440	50	440		19,349	13
14	Roof			1980	16,049	321	50	321		12,839	14
15	Misc Remodeling			1981	7,711		10			7,711	15
16	IDPA Audit Adjustment			1982	351,694		10			351,694	16
17	Decorating			1987	3,285		10			3,285	17
18	Parking Lot			1988	19,937		10			19,937	18
19	Fire Alarm System			1990	37,956		10			37,956	19
20	New Roof			1992	55,787		10			55,787	20
21	Hot Water Tank			1992	3,295		10			3,295	21
22	Building Painting			1993	7,336		5			7,336	22
23	Roof Repairs			1993	434		10			434	23
24	Water Heater			1993	223		15			223	24
25	Boiler Repair			1993	1,415		10			1,415	25
26	Code Alert Fire System			1995	8,559		10			8,559	26
27	Misc			1997	3,013		10			3,013	27
28	Vinyl Floor			1998	4,012		5			4,012	28
29	Ceramic Floor for New Tub			1999	107	6	20	6		105	29
30	Carpet on Walls			2000	2,668		5			2,668	30
31	Metamora Telephone System			2000	7,337		10			7,337	31
32	Tomkat Roofing			2001	18,760		10			18,760	32
33	Hobert Corp			2001	1,555		10			1,555	33
34	Asphalt Repair			2002	2,900		8			2,900	34
35	75 Gallon 365M ASME Water Heater			2006	5,225		10			5,225	35
36	ULTRA CARE 709 BED LAMINATE PANELS			2006	5,809	387	15	387		5,225	36

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

See Page 12A, Line 70 for total

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number St Joseph Nursing Home # 0005637 Report Period Beginning: 7/1/18 Ending: 6/30/19

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	Hoyer Prof Patient Lift	2006	$ 3,020	$	10	$	$	$ 3,020	37
38	Hoyer Prof Vertical Patient Lift w/Scale	2006	4,249		10			4,249	38
39	Concrete Sidewalk	2007	5,220	348	15	348		4,350	39
40	Roofing	2007	20,986		10			20,986	40
41	Fire Dampers	2007	13,100	873	15	873		10,917	41
42	Beds (16)	2007	19,904	1,327	15	1,327		16,591	42
43	Door Alarm System	2007	20,963	1,398	15	1,398		17,473	43
44	Equipment - Nursing Service	2008	21,360	1,424	15	1,424		15,171	44
45	Kitchen Suppression Hood	2010	3,321		5			3,321	45
46	Modify Gas Piping to Kitchen	2010	1,585		5			1,585	46
47	Air Conditioning Unit	2011	45,717	2,286	20	2,286		22,859	47
48	Medical Equipment -Defibrilator	2011	1,562	156	10	157	1	1,562	48
49	Lounge Remodel: Wall Repair and Paint	2012	1,100	110	10	110		990	49
50	Lounge Remodel: Flooring (Carpeting) Install	2012	3,465	173	20	173		1,558	50
51	Rehab Room Upgrade: Paint, Vinyl Floor	2012	4,344	434	10	434		3,907	51
52	Water Heater and Booster	2012	4,817	241	20	241		2,169	52
53	Dining Room Lights	2013	1,137	114	10	114		911	53
54	Dining Room Door	2013	7,445	745	10	745		5,648	54
55	Land Improvements - Earthwork, Plants, Mobila	2013	7,510	751	10	751		5,320	55
56	Adjustment for PY Depreciation							31,446	56
57	Chapel Flooring and Painting	2014	19,580	783	25	783		5,351	57
58	Synthetic Wall Guard-Whole Facility (Lower Wall Covering)	2014	36,550	1,462	25	1,462		10,112	58
59	Concrete Flooring-External-Memorial Garden Patio	2014	35,808	2,387	15	2,387		16,510	59
60	Garage Roof Replacement	2015	1,250	125	10	125		635	60
61	Ice Machine Compressor Replacement	2015	650	120	5	119	(1)	650	61
62	Water Heater	2016	7,656	1,531	5	1,531		6,507	62
63	Air Conditioning Unit	2018	84,690	4,235	20	4,235		10,587	63
64	Wiring Throughtout Building for Wifi	2018	39,982	7,996	5	7,996		11,994	64
65	Water Softener	2019	8,028	1,606	5	1,606		2,409	65
66	Blinds-Resident Rooms	2019	7,062	1,412	5	1,412		2,118	66
67	Piping and Wiring for Dishwasher	2019	3,800	380	5	380		380	67
68	Replace Transfer Switch	2019	4,508	451	5	451		451	68
69	Replace Pump, Pump Seal and Flame Safeguard	2020	26,578	2,658	5	2,658		2,658	69
70	TOTAL (lines 4 thru 69)		$ 2,844,011	$ 55,229		$ 55,229	$	$ 2,612,924	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number St Joseph Nursing Home # 0005637 Report Period Beginning: 7/1/18 Ending: 6/30/19

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		$ 2,844,011	$ 55,229		$ 55,229	$	$ 2,612,924	1
2	Replace Coil	2020	9,790	979	5	979		979	2
3									3
4									4
5	Additional Book Depreciation			3,855			(3,855)		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	TOTAL (lines 1 thru 33)		$ 2,853,801	$ 60,063		$ 56,208	$ (3,855)	$ 2,613,903	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number St Joseph Nursing Home # 0005637 Report Period Beginning: 7/1/18 Ending: 6/30/19

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	$ 173,796	$ 19,623	$ 19,623	$	5-20 Years	$ 77,761	71
72	Current Year Purchases	61,262	2,418	6,126	3,708	5 Years	6,126	72
73	Fully Depreciated Assets	682,121					682,121	73
74								74
75	TOTALS	$ 917,179	$ 22,041	$ 25,749	$ 3,708		$ 766,008	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	Nursing Home	Chevy Caprice & Pick Up	1987	$ 24,879	$	$	$	10	$ 24,879	76
77	Nursing Home	Misc Other	Various	9,476				10	9,476	77
78	Nursing Home	2008 Med Duty Vehicle	2008	46,866				10	46,866	78
79	Nursing Home	IDOT Grant of the Van	2020	40,113	2,006	2,006		10	2,006	79
80	TOTALS			$ 121,334	$ 2,006	$ 2,006	$		$ 83,227	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)	$ 3,918,014	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 84,110	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 83,963	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (147)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,463,138	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	Sisters' Share of Building	$ 63,491	$	$ 63,491	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 63,491	$	$ 63,491	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93	N/A		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.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number St Joseph Nursing Home # 0005637 Report Period Beginning: 7/1/18 Ending: 6/30/19

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:	N/A			$			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. N/A
This amount was calculated by dividing the total amount to be amortized N/A
by the length of the lease N/A .

9. Option to Buy: ☐ YES ☒ NO Terms: N/A *

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.	/2020	$
13.	/2021	$
14.	/2022	$

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: N/A
(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	N/A				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.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number St Joseph Nursing Home # 0005637 Report Period Beginning: 7/1/18 Ending: 6/30/19

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.

SEE ACCOUNTANTS' PREPARATION REPORT

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	39(3)	hrs	$	7,000	$ 133,873	$	7,000	$ 133,873	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		3,790	69,253		3,790	69,253	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(2), (3)	hrs		7,381	141,476		7,381	141,476	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				79,518		79,518	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Oxygen	39(2)					8,265		8,265	12
13	Other (specify): Lab/X-Ray	39(3)				10,988			10,988	13
14	TOTAL			$	18,171	$ 355,590	$ 87,783	18,171	$ 443,373	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.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number St Joseph Nursing Home # 0005637 Report Period Beginning: 7/1/18 Ending: 6/30/19

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 6/30/19 (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	$ 1,275,583	$ 1,275,583	1
2	Cash-Patient Deposits	27,537	27,537	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 709,000)	439,246	439,246	3
4	Supply Inventory (priced at)	15,426	15,426	4
5	Short-Term Investments			5
6	Prepaid Insurance	4,984	4,984	6
7	Other Prepaid Expenses	2,690	2,690	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,765,466	$ 1,765,466	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		25,700	13
14	Buildings, at Historical Cost	1,542,375	1,774,117	14
15	Leasehold Improvements, at Historical Cost	1,327,259	1,079,684	15
16	Equipment, at Historical Cost	1,023,945	1,038,513	16
17	Accumulated Depreciation (book methods)	(3,463,474)	(3,463,138)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	449,745	449,745	21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 879,850	$ 904,621	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,645,316	$ 2,670,087	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 591,419	$ 591,419	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	27,537	27,537	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	193,554	193,554	30
31	Accrued Taxes Payable (excluding real estate taxes)	54,937	54,937	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 Expenses	8,365	8,365	36
37	Due to Third Party Payers\Def Rev	413,861	413,861	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,289,673	$ 1,289,673	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,242,082	1,242,082	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	PPP Loan	655,835	655,835	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,897,917	$ 1,897,917	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,187,590	$ 3,187,590	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (542,274)	$ (517,503)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,645,316	$ 2,670,087	48

SEE ACCOUNTANTS' PREPARATION REPORT

***(See instructions.)**

Facility Name & ID Number St Joseph Nursing Home # 0005637 Report Period Beginning: 7/1/18 Ending: 6/30/19

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (559,083)	1
2	Restatements (describe):		2
3	**Prior Period Adjustment**	(15,855)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (574,938)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	32,664	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)**	$ 32,664	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)**	$ (542,274)	24 *

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

SEE ACCOUNTANTS' PREPARATION REPORT

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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	$ 6,461,010	1
2	Discounts and Allowances for all Levels	(1,324,788)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,136,222	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	148,171	6
7	Oxygen	2,010	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 150,181	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	150,122	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	742	12
13	Barber and Beauty Care	5,538	13
14	Non-Patient Meals	30,463	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	5,639	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	220	19
20	Radiology and X-Ray	(2,951)	20
21	Other Medical Services	40,243	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 230,016	23
	D. Non-Operating Revenue		
24	Contributions	55,882	24
25	Interest and Other Investment Income***	713	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 56,595	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income/Sisters Maintenance	14,426	28
28a	Prior Year Voided Checks	5,241	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 19,667	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,592,681	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,047,327	31
32	Health Care	2,204,455	32
33	General Administration	1,317,971	33
	B. Capital Expense		
34	Ownership	105,151	34
	C. Ancillary Expense		
35	Special Cost Centers	687,336	35
36	Provider Participation Fee	197,777	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,560,017	40
41	**Income before Income Taxes (line 30 minus line 40)****	32,664	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 32,664	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,990,703	44
45	Private Pay - Net Inpatient Revenue	2,130,287	45
46	Medicare - Net Inpatient Revenue	973,221	46
47	Other-(specify) Managed Care	42,011	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,136,222	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes 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.**

SEE ACCOUNTANTS' PREPARATION REPORT

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

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,083	2,203	$ 85,859	$ 38.97	1
2	Assistant Director of Nursing					2
3	Registered Nurses	14,773	15,884	481,456	30.31	3
4	Licensed Practical Nurses	15,226	17,170	433,620	25.25	4
5	CNAs & Orderlies	56,559	60,946	936,138	15.36	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,936	2,080	38,160	18.35	9
10	Activity Assistants	3,538	3,898	43,533	11.17	10
11	Social Service Workers	78	78	1,720	22.05	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	27,372	29,849	313,293	10.50	15
16	Dishwashers					16
17	Maintenance Workers	5,306	5,849	98,578	16.85	17
18	Housekeepers	11,672	12,634	110,160	8.72	18
19	Laundry	6,333	6,803	61,319	9.01	19
20	Administrator	1,784	1,968	94,808	48.17	20
21	Assistant Administrator					21
22	Other Administrative	2,516	2,648	52,723	19.91	22
23	Office Manager					23
24	Clerical	8,722	9,922	140,392	14.15	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)	157,898	171,932	$ 2,891,759 *	$ 16.82	34

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	111	$ 7,233	L1, C3	35
36	Medical Director	Monthly	18,000	L9, C3	36
37	Medical Records Consultant	6	613	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	6,416	L10, C3	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	33	3,842	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	150	$ 36,104		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	7	$ 536	L10, C3	50
51	Licensed Practical Nurses	8	312	L10, C3	51
52	Certified Nurse Assistants/Aides	38	893	L10, C3	52
53	TOTAL (lines 50 - 52)	53	$ 1,741		53

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

** See instructions.

Facility Name & ID Number St Joseph Nursing Home # 0005637 Report Period Beginning: 7/1/18 Ending: 6/30/19

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Tim Wiley	Administrator	0	$ 29,617
Michelle Urnikis	Administrator	0	65,191
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 94,808

B. Administrative - Other

Description	Amount
Franciscan Advisory Services	$ 292,396
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 292,396

C. Professional Services

Vendor/Payee	Type	Amount
Brown Smith Wallace	Accounting	$ 26,041
Point Click Care	Accounting Software	32,236
Waystar	Billing Consultant	2,688
Templin Healthcare Accounting	Accounting	4,743
Galaxy	Payroll system	1,048
Kronos	Payroll timekeeping system	3,146
ABG Retirement Plan Services	Benefit Plan Consulting	1,470
Daniel Maher	Legal	200
Clear Path	Computer Support	7,504
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 79,076

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 59,968
Unemployment Compensation Insurance	9,877
FICA Taxes	231,762
Employee Health Insurance	291,229
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Incentives	3,379
Employee Physicals	12,716
Life Insurance	912
Other Employee Benefits	4,928
TOTAL (agree to Schedule V, line 22, col.8)	$ 614,771

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

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	6,022
Health Care Worker Background Check	
(Indicate # of checks performed 28)	280
Patient Background Checks	
Miscellaneous Licenses and Fees	991
Miscellaneous Dues	549
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 7,842

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	198
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 198

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number St Joseph Nursing Home # 0005637 Report Period Beginning: 7/1/18 Ending: 6/30/19

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? **5 Yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **20,943** 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.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **197,777**
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.

SEE ACCOUNTANTS' PREPARATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **30,463**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **50**
d. Have vehicle usage logs been maintained? **No**
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: **Brown Smith Wallace, LLC**

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

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