

		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.

<p>I. IDPH License ID Number: <u>8025355</u></p> <p>Facility Name: <u>St Josephs Medical Center</u></p> <p>Address: <u>2220 E Washington St</u> <u>Bloomington</u> <u>61701</u> Number City Zip Code</p> <p>County: <u>McLean</u></p> <p>Telephone Number: <u>(309) 662-3311</u> Fax # <u>(309) 662-7143</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>3/25/1988</u></p> <p>Type of Ownership:</p> <table style="width: 100%;"> <tr> <td><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td> <input checked="" type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____ </td> <td> <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____ </td> <td> <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____ </td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: _____ Telephone Number: (____) _____ Email Address: _____</p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>10/1/2019</u> to <u>09/30/2020</u> 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.</p> <p style="text-align: center;">Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 20%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;">(Signed) _____ (Type or Print Name) <u>Michelle A. Carrothers</u> (Title) <u>VP Strategic Reimbursement</u></td> </tr> <tr> <td style="padding: 5px;">Paid Preparer</td> <td style="padding: 5px;">(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) (____) _____ Fax # (____) _____</td> </tr> </table> <p style="text-align: center; font-weight: bold;">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</p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Michelle A. Carrothers</u> (Title) <u>VP Strategic Reimbursement</u>	Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) (____) _____ Fax # (____) _____
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL									
<input checked="" type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____									
Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Michelle A. Carrothers</u> (Title) <u>VP Strategic Reimbursement</u>										
Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) (____) _____ Fax # (____) _____										

Facility Name & ID Number St Josephs Medical Center

8025355 Report Period Beginning: 10/1/2019 Ending: 09/30/2020

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	12	Skilled (SNF)	12	4,392	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	12	TOTALS	12	4,392	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	95		1,777	1,872	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	95		1,777	1,872	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 42.62%

D. How many bed reserve days during this year were paid by the Department?
 _____ (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)

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

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

I. On what date did you start providing long term care at this location?
 Date started 01/11/1988

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

K. Was the facility certified for Medicare during the reporting year?
 YES NO If YES, enter number of beds certified 12 and days of care provided 3,748

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCURAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: N/A Fiscal Year: 10/01/2019 - 09/30/20

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

Facility Name & ID Number St Josephs Medical Center # 8025355 Report Period Beginning: 10/1/2019 Ending: 09/30/2020

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary			115,399	115,399		115,399	115,399			1
2	Food Purchase										2
3	Housekeeping			59,668	59,668		59,668	59,668			3
4	Laundry			30,281	30,281		30,281	30,281			4
5	Heat and Other Utilities			66,116	66,116		66,116	66,116			5
6	Maintenance			84,712	84,712		84,712	84,712			6
7	Other (specify):*										7
8	TOTAL General Services			356,176	356,176		356,176	356,176			8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	637,053		129,570	766,623		766,623	766,623			10
10a	Therapy										10a
11	Activities										11
12	Social Services			117,591	117,591		117,591	117,591			12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*		34,577	4,956	39,533		39,533	39,533			15
16	TOTAL Health Care and Programs	637,053	34,577	252,117	923,747		923,747	923,747			16
	C. General Administration										
17	Administrative			226,101	226,101		226,101	226,101			17
18	Directors Fees										18
19	Professional Services										19
20	Dues, Fees, Subscriptions & Promotions										20
21	Clerical & General Office Expenses										21
22	Employee Benefits & Payroll Taxes			182,611	182,611		182,611	182,611			22
23	Inservice Training & Education										23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice										26
27	Other (specify):*										27
28	TOTAL General Administration			408,712	408,712		408,712	408,712			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	637,053	34,577	1,017,005	1,688,635		1,688,635	1,688,635			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.

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					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			78,282	78,282		78,282		78,282			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			78,282	78,282		78,282		78,282			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			14,854	14,854		14,854		14,854			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			14,854	14,854		14,854		14,854			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	637,053	34,577	1,110,141	1,781,771		1,781,771		1,781,771			45

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

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

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	A & G	\$ 197,932	OSF Healthcare System	100.00%	\$ 133,809	\$ (64,123)	1
2	V	Maint & Repairs	15,831	OSF Healthcare System	100.00%	15,831		2
3	V	Nursing Admin		OSF Healthcare System	100.00%	34,773	34,773	3
4	V	Social Services	92,166	OSF Healthcare System	100.00%	94,738	2,572	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		\$ 305,929			\$ 279,151	\$ * (26,778)	14

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

Facility Name & ID Number St Josephs Medical Center

8025355 Report Period Beginning: 10/1/2019

Ending: 9/30/2020

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

Name of Related Organization St. Joseph Medical Center - SNF
 Street Address 220 E. Washington
 City / State / Zip Code Bloomington IL 61701
 Phone Number (309) 662-3311
 Fax Number (309) 662-7143

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	30	Depreciation - Building	Square Feet	362,333	40	\$ 5,614,470	\$ 5,052	\$ 78,282	1
2	30	Depreciation - Equipment	Dollar Value	5,845,608	32	6,056,047	8,950	9,272	2
3	22	Employee Benefits	Gross Salaries	47,532,307	43	13,695,843	633,761	182,610	3
4	17	A & G	Accum Cost	109,503,633	48	26,414,859	2,934,901	937,307	4
5	6	Maint & Repair	Square Feet	263,995	38	4,426,654	999,649	5,052	5
6	5	Oper of Plant	Square Feet	250,722	37	3,281,214	232,237	5,052	6
7	4	Laundry & Linen	Pounds of Laundry	743,336	12	755,684	30,531	29,786	7
8	3	Housekeeping	Square Feet)	244,698	35	2,890,065	1,606,510	5,052	8
9	1	Dietary	Patient Days	144,294	4	1,483,388	516,787	10,030	9
10	1	Cafeteria	FTE's	62,552	36	605,664	415,057	1,269	10
11	10	Nursing Admin	FTE's	42,591	11	4,290,738	1,369,066	1,269	11
12	15	Central Supply	Inventory Issues	14,946,219	25	164,779	97,559	15,474	12
13	10	Medical Records	Gross Charges	709,967,925	32	858,859	391,497	1,427,671	13
14	12	Social Services	Total Patient Days	29,227	3	1,835,917	1,872	117,591	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 72,374,181	\$ 8,593,794	\$ 1,099,773	25

Facility Name & ID Number St Josephs Medical Center

8025355

Report Period Beginning:

10/1/2019 Ending:

09/30/2020

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 5,052 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

C. Does the Operating Entity? (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? (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 NO
 If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1		<u>5,052</u>		\$ <u>19,799</u>	1
2					2
3	TOTALS	5,052		\$ 19,799	3

Facility Name & ID Number St Josephs Medical Center

8025355

Report Period Beginning:

10/1/2019

Ending:

09/30/2020

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	12		1968	1968	\$ 1,795,201	\$ 34,617	Various	\$ 34,617	\$	\$ 920,352	4
5											5
6											6
7											7
8											8
	Improvement Type**										
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

*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

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	
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								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 1,795,201	\$ 34,617		\$ 34,617	\$	\$ 920,352	70

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

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	\$ 283,434	\$ 6,584	\$	\$ (6,584)		\$ 239,558	71
72	Current Year Purchases	324,085	15,941		(15,941)		15,941	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 607,519	\$ 22,525	\$	\$ (22,525)		\$ 255,499	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				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	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)	\$ 2,422,519	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 57,142	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 34,617	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (22,525)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,175,851	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number St Josephs Medical Center

8025355

Report Period Beginning: 10/1/2019

Ending: 09/30/2020

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 09/30/2020

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 1,894,164	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 77,434,982)	23,117,029		3
4	Supply Inventory (priced at)	3,584,876		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	2,501,050		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 31,097,119	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments	271,513,539		12
13	Land	1,603,420		13
14	Buildings, at Historical Cost	151,273,759		14
15	Leasehold Improvements, at Historical Cost	190,139		15
16	Equipment, at Historical Cost	62,718,545		16
17	Accumulated Depreciation (book methods)	(119,598,068)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe Minor Equip nondepr	2,192,585		22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 369,893,919	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 400,991,038	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 6,186,898	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	378,438		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	651,097		34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Due to Other Funds</u>	232,150		36
37	<u>Other Current Liabilities</u>	31,715,756		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 39,164,339	\$	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	<u>Other Long-Term Liabilities</u>	631,244		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 631,244	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 39,795,583	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 361,195,455	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 400,991,038	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 350,426,876	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 350,426,876	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	43,462,767	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) Other	2,603,330	15
16	Other (describe) Equity Transfer	(35,297,518)	16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 10,768,579	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)	\$ 361,195,455	24 *

* This must agree with page 17, line 47.

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.

1			
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 1,427,671	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,427,671	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		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		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,427,671	30

2			
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	356,176	31
32	Health Care	923,747	32
33	General Administration	408,712	33
B. Capital Expense			
34	Ownership	78,282	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	14,854	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,781,771	40
41	Income before Income Taxes (line 30 minus line 40)**	(354,100)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (354,100)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$	49

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

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

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

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

Facility Name & ID Number **St Josephs Medical Center**

8025355

Report Period Beginning: **10/1/2019**

Ending:

09/30/2020

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	805	1,282	\$ 61,137	\$ 47.69	1
2	Assistant Director of Nursing					2
3	Registered Nurses	9,663	10,741	356,554	33.20	3
4	Licensed Practical Nurses	1,593	1,878	47,235	25.15	4
5	CNAs & Orderlies	11,205	12,834	172,127	13.41	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers					18
19	Laundry					19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					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)					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)	23,266	26,735	\$ 637,053 *	\$ 23.83	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		\$		35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				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				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$		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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions			
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
			\$	Workers' Compensation Insurance	\$	IDPH License Fee	\$		
				Unemployment Compensation Insurance		Advertising: Employee Recruitment			
				FICA Taxes		Health Care Worker Background Check (Indicate # of checks performed _____)			
				Employee Health Insurance		<u>Patient Background Checks</u>			
				Employee Meals					
				Illinois Municipal Retirement Fund (IMRF)*					
				<u>Various-allocation from Medicare Cost report</u>	<u>182,611</u>				
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$						
B. Administrative - Other									
Description			Amount						
			\$			Less: Public Relations Expense	()		
						Non-allowable advertising	()		
						Yellow page advertising	()		
						TOTAL (agree to Sch. V, line 20, col. 8)	\$		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL (agree to Schedule V, line 22, col.8)	\$ 182,611				
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount	
			\$			\$	Out-of-State Travel	\$	
							In-State Travel		
							Seminar Expense		
							Entertainment Expense	()	
							(agree to Sch. V, line 24, col. 8)		
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$	TOTAL		\$	TOTAL	\$	

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number St Josephs Medical Center

8025355

Report Period Beginning:

10/1/2019

Ending: 09/30/2020

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? N/A
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ Not available Line 15
- (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. \$ 14,854
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. \$ N/A 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? 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? N/A
 - d. Have vehicle usage logs been maintained? N/A
 - e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
 - 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? N/A**
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: KPMG
- (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. N/A
Attach invoices and a summary of services for all architect and appraisal fees.