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: 0035006

Facility Name: St Patricks Residence

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

County: DuPage

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

HFS ID Number:

Date of Initial License for Current Owners: 05/22/1989

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Rachel King **Telephone Number:** 563-484-3819
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2020 to 12/31/2020 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) Kate Marerro
(Title) Administrator

Paid Preparer

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

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

Facility Name & ID Number St Patricks Residence # 0035006 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	206	Skilled (SNF)	206	75,396	1
2		Skilled Pediatric (SNF/PED)			2
3	3	Intermediate (ICF)	3	1,098	3
4		Intermediate/DD			4
5	1	Sheltered Care (SC)	1	366	5
6		ICF/DD 16 or Less			6
7	210	TOTALS	210	76,860	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	31,152	20,727	4,721	56,600	8
9	SNF/PED					9
10	ICF	730	10		740	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	31,882	20,737	4,721	57,340	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.60%

D. How many bed reserve days during this year were paid by the Department?
0 (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

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

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

I. On what date did you start providing long term care at this location?
Date started 05/22/1989

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 5/22/1989 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 206 and days of care provided 3,103

Medicare Intermediary NGS

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/20 Fiscal Year: 12/31/20

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

Facility Name & ID Number St Patricks Residence # 0035006 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	749,071	90,532	25,288	864,891		864,891		864,891			1
2	Food Purchase		408,896		408,896		408,896	(13,836)	395,060			2
3	Housekeeping		64	786,992	787,056		787,056		787,056			3
4	Laundry		3,219		3,219		3,219		3,219			4
5	Heat and Other Utilities			381,434	381,434		381,434	(6,948)	374,486			5
6	Maintenance	317,184	110,634		427,818		427,818		427,818			6
7	Other (specify):*											7
8	TOTAL General Services	1,066,255	613,345	1,193,714	2,873,314		2,873,314	(20,784)	2,852,530			8
	B. Health Care and Programs											
9	Medical Director			2,388	2,388		2,388		2,388			9
10	Nursing and Medical Records	5,407,230	389,703	1,749,937	7,546,870		7,546,870		7,546,870			10
10a	Therapy	128,774		506,832	635,606		635,606		635,606			10a
11	Activities	202,230	19,200	96	221,526		221,526		221,526			11
12	Social Services	124,836	10,806	67,704	203,346		203,346		203,346			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	5,863,070	419,709	2,326,957	8,609,736		8,609,736		8,609,736			16
	C. General Administration											
17	Administrative	134,583		209,821	344,404		344,404		344,404			17
18	Directors Fees											18
19	Professional Services			130,098	130,098		130,098		130,098			19
20	Dues, Fees, Subscriptions & Promotions			178,859	178,859		178,859	(55,946)	122,913			20
21	Clerical & General Office Expenses	573,732	78,167	720,156	1,372,055		1,372,055	(259,048)	1,113,007			21
22	Employee Benefits & Payroll Taxes			2,012,512	2,012,512		2,012,512		2,012,512			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,229	3,229		3,229	(3,229)				24
25	Other Admin. Staff Transportation			272	272		272		272			25
26	Insurance-Prop.Liab.Malpractice			215,980	215,980		215,980		215,980			26
27	Other (specify):*											27
28	TOTAL General Administration	708,315	78,167	3,470,927	4,257,409		4,257,409	(318,223)	3,939,186			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	7,637,640	1,111,221	6,991,598	15,740,459		15,740,459	(339,007)	15,401,452			29

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

Facility Name & ID Number St Patricks Residence #0035006 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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			708,006	708,006		708,006		708,006			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			27,918	27,918		27,918	(6,034)	21,884			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			14,817	14,817		14,817		14,817			35
36	Other (specify):*											36
37	**TOTAL Ownership**			750,741	750,741		750,741	(6,034)	744,707			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		166,978	224,001	390,979		390,979		390,979			39
40	Barber and Beauty Shops		6,578		6,578		6,578		6,578			40
41	Coffee and Gift Shops			29,288	29,288		29,288	(2,869)	26,419			41
42	Provider Participation Fee			442,620	442,620		442,620		442,620			42
43	Other (specify):* **Marketing**	72,398		39,276	111,674		111,674	(111,674)				43
44	**TOTAL Special Cost Centers**	72,398	173,556	735,185	981,139		981,139	(114,543)	866,596			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	7,710,038	1,284,777	8,477,524	17,472,339		17,472,339	(459,584)	17,012,755			45

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

Facility Name & ID Number St Patricks Residence # 0035006 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(13,836)	2		4
5	Telephone, TV & Radio in Resident Rooms	(6,948)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	(54,555)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(6,034)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(4,492)	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	(166,832)	21		24
25	Fund Raising, Advertising and Promotional	(55,946)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(150,941)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (459,584)		$	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))**	$ (459,584)		37

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

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

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

St Patricks Residence

ID# 0035006

Report Period Beginning: 01/01/2020

Ending: 12/31/2020

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Coffee/Gift Shop Expense	$ (2,869)	41	1
2	Investment Fees	(33,169)	21	2
3	Development Salaries	(72,398)	43	3
4	Fundraising/Special Events Expense	(39,276)	43	4
5	Continuing Education	(1,729)	24	5
6	Non-allowable Travel	(1,500)	24	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**	(150,941)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number St Patricks Residence # 0035006 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(13,836)	0	0	0	0	0	0	0	0	0	0	(13,836)	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	(6,948)	0	0	0	0	0	0	0	0	0	0	(6,948)	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**	(20,784)	0	0	0	0	0	0	0	0	0	0	(20,784)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(55,946)	0	0	0	0	0	0	0	0	0	0	(55,946)	20
21	Clerical & General Office Expenses	(259,048)	0	0	0	0	0	0	0	0	0	0	(259,048)	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	(3,229)	0	0	0	0	0	0	0	0	0	0	(3,229)	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**	(318,223)	0	0	0	0	0	0	0	0	0	0	(318,223)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(339,007)	0	0	0	0	0	0	0	0	0	0	(339,007)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number St Patricks Residence **#** 0035006 **Report Period Beginning:** 01/01/2020 **Ending:** 12/31/2020

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	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(6,034)	0	0	0	0	0	0	0	0	0	0	(6,034)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(6,034)	0	0	0	0	0	0	0	0	0	0	(6,034)	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	(2,869)	0	0	0	0	0	0	0	0	0	0	(2,869)	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(111,674)	0	0	0	0	0	0	0	0	0	0	(111,674)	43
44	**TOTAL Special Cost Centers**	(114,543)	0	0	0	0	0	0	0	0	0	0	(114,543)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(459,584)	0	0	0	0	0	0	0	0	0	0	(459,584)	45

Facility Name & ID Number St Patricks Residence # 0035006 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Page 6 Supplemental		See Page 6 - Supplemental		See Page 6 - Supplemental		

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	Management Fees	$ 209,821		100.00%	$ 209,821	$	1
2	V	21	Administrative - Sisters Comp	103,265		100.00%	103,265		2
3	V	12	Pastoral Care - Sisters	66,791		100.00%	66,791		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			$ 379,877			$ 379,877	$ *	14

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

Facility Name & ID Number St Patricks Residence # 0035006 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

VII. RELATED PARTIES

A. (Continued) **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.**

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Carmelite Sisters for the Aged and	100	None		Carmelite Sisters	Germantown, NY	Religious Order	1
2	Infirm, Inc.				For the Aged and Infirm, Inc.			2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number St Patricks Residence # 0035006 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	See Attached Listing								$		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 St Patricks Residence # 0035006 Report Period Beginning: 01/01/2020 Ending: 2/31/2020

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 ☐

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

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

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

Facility Name & ID Number St Patricks Residence # 0035006 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Key Bank		X	Renovation	No	11/17/20	$ 4,765,000	$ 4,751,114	12/01/45	6.4000	$ 21,884	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Key Bank		X	Line of Credit	No	11/17/20	150,083	150,083		varies	6,034	6
7												7
8												8
9	TOTAL Facility Related						$ 4,915,083	$ 4,901,197			$ 27,918	9
	B. Non-Facility Related*											
10	Non-care related LOC										(6,034)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (6,034)	14
15	TOTALS (line 9+line14)						$ 4,915,083	$ 4,901,197			$ 21,884	15

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

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

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

Facility Name & ID Number St Patricks Residence # 0035006 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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.)		$	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

	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 St Patricks Residence COUNTY DuPage

FACILITY IDPH LICENSE NUMBER 0035006

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 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.			$	$
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 Patricks Residence # 0035006 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

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

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

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number St Patricks Residence # 0035006 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	210		1989	1989	$ 7,786,645	$		$	$	$	4
5			1997	1997	2,194,676						5
6			2000	2000	2,986,981						6
7			2005	2005	882,594						7
8											8
	Improvement Type**										
9	1991 Fixed Assets			1991	4,862						9
10	1993 Fixed Assets			1993	6,887						10
11	1994 Fixed Assets			1994	31,612						11
12	1996 Fixed Assets			1996	2,976						12
13	1997 Fixed Assets			1997	52,566						13
14	1998 Fixed Assets			1998	28,215						14
15	1999 Fixed Assets			1999	6,832						15
16	2000 Fixed Assets			2000	16,581						16
17	2001 Fixed Assets			2001	10,440						17
18	2002 Fixed Assets			2002	3,966						18
19	2005 Fixed Assets			2005	10,924						19
20	2006 Fixed Assets			2006	237,917						20
21	2007 Fixed Assets			2007	185,440						21
22	2008 Fixed Assets			2008	240,356						22
23	2009 Fixed Assets			2009	59,316						23
24	2010 Fixed Assets			2010	54,416						24
25	2011 Fixed Assets			2011	139,614						25
26	2012 Fixed Assets			2012	84,044						26
27	2013 Fixed Assets			2013	45,901						27
28	2014 Fixed Assets			2014	52,957						28
29	2015 Fixed Assets			2015	108,056						29
30	Crowthers Roofing			2016	3,940						30
31	Chase Ink AV Ovrhd Door			2016	1,775						31
32	Reliant electric Relocation Circuit emergency			2016	3,960						32
33	Showalter Roofing (May & July)			2016	7,535						33
34	Nuyen industries Canope employee entrance			2016	8,250						34
35	Noland Sales Corp lobby & hall vinyl plank flooring			2016	27,809						35
36	Chase Ink AV Ovrhd Door -Convent 2nd installment			2016	1,775						36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number St Patricks Residence # 0035006 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	NC Concrete Co.Asphalt replacement	2016	$ 8,340	$		$	$	$	37
38	Ashland Door - Main Diningroom Doors	2017	603						38
39	Ashland Door - Bring maintenance doors up to code	2017	1,220						39
40	Showalter Roofing Services - Convent Roof	2017	1,199						40
41	Key Construction - Replace holding tanks	2017	6,122						41
42	Replacement pump for fire system	2017	685						42
43	Rogers Pump & Sales - Fire pump rebuild	2017	2,903						43
44	Tr from CIP - Cubicle Curtains	2017	2,487						44
45	Gilkerson Masonry Corp - Reseal Convent Masonry	2017	4,400						45
46	Preferred Window and Door - Upgrade sliding doors	2017	6,200						46
47	PH PH Roofing down payment	2017	89,533						47
48	PH Deposit - Replace Patio Door	2017	3,213						48
49	Perkins Eastman Architects - shower upgrade	2017	17,873						49
50	City of Naperville - Shower upgrade	2017	2,227						50
51	Mazur & Son Construction - shower upgrade	2017	349,259						51
52	FSES Survey	2017	3,750						52
53	Perkins Eastman Architects	2017	44,198						53
54	State of Illinois	2017	6,336						54
55	IDPH Plan Review (construction for bathrooms)	2017	5,992						55
56	Shower Upgrade	2017	250,744						56
57	Argueta's Landscaping - Staff Patio Project	2018	1,140						57
58	Ashland Door - Replace Patio Door	2018	3,123						58
59	Roofed Right America - Roofing Services	2018	89,533						59
60	Ashland Door - Install Pemko Door Shoes - life safety	2018	2,908						60
61	Jense Hughes - Life Safety Survey & Report	2018	4,000						61
62	Pete's Carpet Service - Office Carpeting	2018	790						62
63	Key Construction Group - Convent Plumbing	2018	2,529						63
64	State Mechanical Services - Chapel Condenser	2018	13,992						64
65	Sound Incorporated - Paging System upgrade	2018	8,475						65
66	Roofed Right America - Roofing Services	2018	82,084						66
67	ILLCO - Convent cold water supply run/piping	2018	2,252						67
68	Peerless Fence - Garden Fence	2018	14,985						68
69	Precision Control Systems - Convent water line	2018	3,110						69
70	TOTAL (lines 4 thru 69)		$ 16,326,022	$		$	$	$	70

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

Facility Name & ID Number St Patricks Residence # 0035006 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 16,326,022	$		$	$	$	1
2	Garden gate final bill - (Citizens cc)	2018	319						2
3	Sound Incorporated - Paging System upgrade	2018	5,733						3
4	Shower upgrade (from CIP)	2018	121						4
5	Hubert Menu Board	2018	588						5
6	Sound Inc - Paging System upgrades	2019	8,475						6
7	Noland Sales - 3rd floor Flooring	2019	83,205						7
8	Faucets - 3rd floor renovation	2019	219						8
9	Sinks - 3rd floor renovation	2019	250						9
10	Goldseal cabinetry - 3rd floor renovation	2019	4,045						10
11	Constructions specialists -building transition strips-3rd floor reno	2019	524						11
12	Jensen Hughes - Life Safety Survey & Report	2019	4,000						12
13	Inpro - 3rd floor renovation - handrails	2019	190						13
14	Peterson - 3rd floor renovation - Nourishment center construction	2019	6,920						14
15	Peterson - 3rd floor renovation - painting	2019	38,845						15
16	Peterson - 3rd floor renovation - handrails (remove old & install n	2019	26,500						16
17	Hospital grade outlets - life safety	2019	666						17
18	Greenbee - LED project 3rd floor	2019	9,533						18
19	3rd floor renovation - nourishment center (drain and electric)	2019	332						19
20	Sherwin Williams - 3rd floor renovation - paint	2019	818						20
21	Peterson - 3rd floor renovation - handrails & doors	2019	5,825						21
22	Reliant - Med room outlets (5)	2019	1,250						22
23	Twin Bros Paving - parking lot	2019	27,625						23
24	CIP - 3rd floor renovation (cabinets/countertops,	2019	12,812						24
25	furniture/finishes) - common areas (dining/hallways/								25
26	nursing stations)								26
27	Shade Sail Awning System - installed in rear patio of SNF	2020	29,600						27
28	Cooling Tower Repair - steel coating, replace fill, eliminator	2020	24,999						28
29	and air inlet louvers								29
30	FSES Survey - fire safety evaluation system	2020	4,400						30
31	3rd floor renovation - nourishment center (drain and electric)	2020	27,469						31
32	furniture/finishes) - common areas (dining/hallways/								32
33	Plubming Project Mechanical Room - replaced leaking parts (ball	2020	2,333						33
34	TOTAL (lines 1 thru 33)		$ 16,653,618	$		$	$	$	34

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

Facility Name & ID Number St Patricks Residence # 0035006 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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		$ 16,653,618	$		$	$	$	1
2									2
3	Financial Statement Depreciation			447,426		447,426		11,369,035	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
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19									19
20									20
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22									22
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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)		$ 16,653,618	$ 447,426		$ 447,426	$	$ 11,369,035	34

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

Facility Name & ID Number St Patricks Residence # 0035006 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	$ 3,069,964	$ 239,619	$ 239,619	$	various	$ 4,998,808	71
72	Current Year Purchases	234,331	20,561	20,561		various	20,561	72
73	Fully Depreciated Assets	3,067,774						73
74								74
75	TOTALS	$ 6,372,069	$ 260,180	$ 260,180	$		$ 5,019,369	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		2001 Dodge Grand Caravan	2,004	$ 12,026	$	$	$	5	$ 12,026	76
77		2008 Chevy Bus	2,007	49,512				10	49,512	77
78		2018 Silverado Pickup	2,008	23,591				10	23,591	78
79		See Attached		14,913	400	400		10	14,913	79
80	TOTALS			$ 100,042	$ 400	$ 400	$		$ 100,042	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)	$ 23,764,319	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 708,006	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 708,006	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 16,488,446	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	CIP	$ 325,877	92
93			93
94			94
95		$ 325,877	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 Patricks Residence # 0035006 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

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

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

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: $ 14,817 Description: See attached
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number St Patricks Residence # 0035006 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		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	39-2, 39-3	# of prescrpts	271,073					271,073	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): X-Ray, Lab, Ambulanc	39-3		119,906					119,906	12
13	Other (specify):									13
14	TOTAL			$ 390,979		$	$		$ 390,979	14

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

Facility Name & ID Number St Patricks Residence # 0035006 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2020 (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	$ 3,513,868	$	1
2	Cash-Patient Deposits	17,400		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 628,138)	1,164,047		3
4	Supply Inventory (priced at)	88,052		4
5	Short-Term Investments	1,825,213		5
6	Prepaid Insurance	33,589		6
7	Other Prepaid Expenses	30,601		7
8	Accounts Receivable (owners or related parties)	5,623,859		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 12,296,629	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	9,339,997		12
13	Land	638,590		13
14	Buildings, at Historical Cost	16,417,517		14
15	Leasehold Improvements, at Historical Cost	236,091		15
16	Equipment, at Historical Cost	6,472,111		16
17	Accumulated Depreciation (book methods)	(16,488,446)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe CIP	325,877		22
23	Other(specify): A/R Non-Residents	1,140,108		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 18,081,845	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 30,378,474	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 736,013	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	17,400		28
29	Short-Term Notes Payable	1,251,058		29
30	Accrued Salaries Payable	229,852		30
31	Accrued Taxes Payable (excluding real estate taxes)	380,248		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	1,683		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	1,837,041		36
37	Other Accrued Expenses (see attached)	1,324,274		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 5,777,569	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	930,771		39
40	Mortgage Payable			40
41	Bonds Payable	5,091,346		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Grant/Trust/Fund Liabilities	970,896		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 6,993,013	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 12,770,582	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 17,607,892	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 30,378,474	$	48

*(See instructions.)

Facility Name & ID Number St Patricks Residence # 0035006 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 17,406,725	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 17,406,725	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	201,171	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) **rounding**	(4)	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 201,167	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 17,607,892	24 *

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

Facility Name & ID Number St Patricks Residence # 0035006 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	$ 17,231,808	1
2	Discounts and Allowances for all Levels	(3,963,225)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 13,268,583	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	993,615	6
7	Oxygen	31,200	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,024,815	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	2,869	12
13	Barber and Beauty Care	10,513	13
14	Non-Patient Meals	13,836	14
15	Telephone, Television and Radio	6,948	15
16	Rental of Facility Space	124,171	16
17	Sale of Drugs	209,706	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	70,904	19
20	Radiology and X-Ray	11,340	20
21	Other Medical Services	272,739	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 723,026	23
	D. Non-Operating Revenue		
24	Contributions	1,416,091	24
25	Interest and Other Investment Income***	917,352	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,333,443	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	See Supplemental Schedule	323,643	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 323,643	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 17,673,510	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,873,314	31
32	Health Care	8,609,736	32
33	General Administration	4,257,409	33
	B. Capital Expense		
34	Ownership	750,741	34
	C. Ancillary Expense		
35	Special Cost Centers	538,519	35
36	Provider Participation Fee	442,620	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 17,472,339	40
41	**Income before Income Taxes (line 30 minus line 40)****	201,171	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 201,171	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,738,998	44
45	Private Pay - Net Inpatient Revenue	6,526,495	45
46	Medicare - Net Inpatient Revenue	949,805	46
47	Other-(specify) Insurance	27,045	47
48	Other-(specify) Managed Care	4,026,240	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 13,268,583	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 Patricks Residence # 0035006 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	2,169	2,169	$ 105,363	$ 48.58	1
2	Assistant Director of Nursing					2
3	Registered Nurses	77,951	77,951	2,778,225	35.64	3
4	Licensed Practical Nurses	25,671	25,671	725,618	28.27	4
5	CNAs & Orderlies	97,889	97,889	1,707,515	17.44	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	8,156	8,156	144,256	17.69	8
9	Activity Director					9
10	Activity Assistants	14,765	14,765	202,230	13.70	10
11	Social Service Workers	6,240	6,240	124,836	20.01	11
12	Dietician	2,234	2,234	57,017	25.52	12
13	Food Service Supervisor	4,407	4,407	129,038	29.28	13
14	Head Cook					14
15	Cook Helpers/Assistants	44,256	44,256	563,016	12.72	15
16	Dishwashers					16
17	Maintenance Workers	16,484	16,484	317,184	19.24	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,080	2,080	134,583	64.70	20
21	Assistant Administrator					21
22	Other Administrative	15,738	15,738	405,627	25.77	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	6,646	6,646	113,174	17.03	31
32	Other Health C: Admissions	4,669	4,669	129,958	27.83	32
33	Other(specify) Marketing	2,295	2,295	72,398	31.55	33
34	TOTAL (lines 1 - 33)	331,650	331,650	$ 7,710,038 *	$ 23.25	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	120	27,996	10-3	36
37	Medical Records Consultant	51	3,594	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		12,623	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant		255	10-3	42
43	Speech Therapy Consultant				43
44	Activity Consultant		96	11-3	44
45	Social Service Consultant				45
46	Other(specify) Risk Management Consult		1,500	19-3	46
47	Market Analysis		9,392	21-3	47
48					48
49	TOTAL (lines 35 - 48)	171	$ 55,456		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	637	$ 28,131	10-3	50
51	Licensed Practical Nurses	7,163	317,122	10-3	51
52	Certified Nurse Assistants/Aides	50,045	1,356,960	10-3	52
53	TOTAL (lines 50 - 52)	57,845	$ 1,702,213		53

Facility Name & ID Number St Patricks Residence # 0035006 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Kate Marrero	Administrator	0	$ 134,583
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 134,583

B. Administrative - Other

Description	Amount
Carmelite System Dues	$ 209,821
TOTAL (agree to Schedule V, line 17, col. 3)	$ 209,821
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Nixon Peabody	Legal	$ 96,655
Smith & Downey	Legal	7,979
CLA	Accounting	23,964
IPMG	Consulting	1,500
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 130,098

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 207,736
Unemployment Compensation Insurance	
FICA Taxes	571,928
Employee Health Insurance	945,693
Employee Meals	13,814
Illinois Municipal Retirement Fund (IMRF)*	
Life & Disability Insurance	28,556
Staff Development	17,320
Gifts and Events	7,721
Other Benefits	81,933
Onboarding and Tuition	50,014
EAP	3,655
401k/Pension	84,142
TOTAL (agree to Schedule V, line 22, col.8)	$ 2,012,512

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 2,300
Advertising: Employee Recruitment	39,390
Health Care Worker Background Check	
(Indicate # of checks performed 90)	896
Patient Background Checks 392	3,920
Dues and Subscriptions	16,338
Software Fees	60,069
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 122,913

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 1,500
In-State Travel	
Seminar Expense	1,729
Non-allowable adjustment (Pg 5A)	(3,229)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number St Patricks Residence # 0035006 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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? **Yes**
If YES, give association name and amount. **Leading Age - $16,615**

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

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **68,871** Line **10**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **442,620**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **No** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **13,836**

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

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

(18) Have all costs which do not relate to the provision of long term care been adjusted out 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.