

Facility Name & ID Number St Patricks Residence

0035006 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	32,036	29,038	6,161	67,235	8
9	SNF/PED					9
10	ICF	268	763		1,031	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	32,304	29,801	6,161	68,266	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.06%

D. How many bed-hold days during this year were paid by the Department?

0 (Do not include bed-hold 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

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 5/22/1989

J. Was the facility purchased or leased after January 1, 1978?

YES Date 5/22/1989 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 206 and days of care provided 6,161

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/15 Fiscal Year: 12/31/15

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

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	898,174	90,979		989,153		989,153		989,153		1
2	Food Purchase		467,955		467,955		467,955	(120)	467,835		2
3	Housekeeping			798,494	798,494		798,494		798,494		3
4	Laundry		2,597		2,597		2,597		2,597		4
5	Heat and Other Utilities			310,319	310,319		310,319	(18,056)	292,263		5
6	Maintenance	303,555	48,078	147,670	499,303		499,303		499,303		6
7	Other (specify):*										7
8	TOTAL General Services	1,201,729	609,609	1,256,483	3,067,821		3,067,821	(18,176)	3,049,645		8
	B. Health Care and Programs										
9	Medical Director			25,200	25,200		25,200		25,200		9
10	Nursing and Medical Records	5,882,260	328,528	1,058,751	7,269,539		7,269,539		7,269,539		10
10a	Therapy	179,048	5,833	1,300	186,181		186,181		186,181		10a
11	Activities	290,049	43,011		333,060		333,060		333,060		11
12	Social Services	335,560	21,352		356,912		356,912	(1,600)	355,312		12
13	CNA Training										13
14	Program Transportation			6,255	6,255		6,255		6,255		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	6,686,917	398,724	1,091,506	8,177,147		8,177,147	(1,600)	8,175,547		16
	C. General Administration										
17	Administrative	296,287		148,599	444,886		444,886		444,886		17
18	Directors Fees										18
19	Professional Services			143,347	143,347		143,347		143,347		19
20	Dues, Fees, Subscriptions & Promotions			63,982	63,982		63,982	(3,391)	60,591		20
21	Clerical & General Office Expenses	505,562	40,239	159,247	705,048		705,048	(173,802)	531,246		21
22	Employee Benefits & Payroll Taxes			1,862,160	1,862,160		1,862,160	(15,418)	1,846,742		22
23	Inservice Training & Education										23
24	Travel and Seminar			7,869	7,869		7,869	(7,869)			24
25	Other Admin. Staff Transportation			22,078	22,078		22,078	(22,078)			25
26	Insurance-Prop.Liab.Malpractice			193,183	193,183		193,183		193,183		26
27	Other (specify):*										27
28	TOTAL General Administration	801,849	40,239	2,600,465	3,442,553		3,442,553	(222,558)	3,219,995		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	8,690,495	1,048,572	4,948,454	14,687,521		14,687,521	(242,334)	14,445,187		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:

01/01/2015

Ending:

12/31/2015

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	D. Ownership											
30	Depreciation			542,275	542,275	542,275	272,408	814,683				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			542,275	542,275	542,275	272,408	814,683				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		357,184	1,006,505	1,363,689	1,363,689		1,363,689				39
40	Barber and Beauty Shops	42,993			42,993	42,993		42,993				40
41	Coffee and Gift Shops		51,675		51,675	51,675	(51,675)					41
42	Provider Participation Fee			490,439	490,439	490,439		490,439				42
43	Other (specify):*	130,314		118,775	249,089	249,089	(249,089)					43
44	TOTAL Special Cost Centers	173,307	408,859	1,615,719	2,197,885	2,197,885	(300,764)	1,897,121				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	8,863,802	1,457,431	7,106,448	17,427,681	17,427,681	(270,690)	17,156,991				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: 01/01/2015

Ending: 12/31/2015

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(120)	2		4
5	Telephone, TV & Radio in Resident Rooms	(18,056)	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	272,408	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	(13,480)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				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	(64,775)	21		24
25	Fund Raising, Advertising and Promotional				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	(446,667)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (270,690)		\$	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	2	
		Amount	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
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (270,690)		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	2	3	4	
		Yes	No	Amount	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: 01/01/2015

Ending: 12/31/2015

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Stamps	\$ (291)	21	1
2	Chapel Services	(1,600)	12	2
3	Coffee/Gift Shop Expense	(50,510)	41	3
4	Happy Hour Expense	(1,165)	41	4
5	Investment Fees	(63,932)	21	5
6	Development Salaries	(130,314)	43	6
7	Development/Marketing Expense	(47,062)	43	7
8	Golf Outing Expense	(36,276)	43	8
9	Fund Raising Expense	(30,551)	43	9
10	Resident Person Exp	(4,886)	43	10
11	Continuing Education	(7,869)	24	11
12	Non-allowable Travel	(22,078)	25	12
13	Loggng Fees	(3,391)	20	13
14	Volunteer Coordinator	(31,324)	21	14
15	Non-allowable Employee Benefits	(15,418)	22	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		(446,667)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number St Patricks Residence# 0035006

Report Period Beginning:

01/01/2015

Ending:

12/31/2015

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

	Operating Expenses	PAGES	PAGE	SUMMARY										
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(120)	0	0	0	0	0	0	0	0	0	0	(120)	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	(18,056)	0	0	0	0	0	0	0	0	0	0	(18,056)	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	(18,176)	0	(18,176)	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	(1,600)	0	0	0	0	0	0	0	0	0	0	(1,600)	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	(1,600)	0	(1,600)	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	(3,391)	0	0	0	0	0	0	0	0	0	0	(3,391)	20
21	Clerical & General Office Expenses	(173,802)	0	0	0	0	0	0	0	0	0	0	(173,802)	21
22	Employee Benefits & Payroll Taxes	(15,418)	0	0	0	0	0	0	0	0	0	0	(15,418)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(7,869)	0	0	0	0	0	0	0	0	0	0	(7,869)	24
25	Other Admin. Staff Transportation	(22,078)	0	0	0	0	0	0	0	0	0	0	(22,078)	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	(222,558)	0	(222,558)	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(242,334)	0	(242,334)	29									

STATE OF ILLINOIS

Facility Name & ID Number St Patricks Residence# 0035006

Report Period Beginning:

01/01/2015 Ending:

Summary B

12/31/2015

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

	Capital Expense	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)	
	D. Ownership													
30	Depreciation	272,408	0	0	0	0	0	0	0	0	0	0	272,408	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	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	272,408	0	0	0	0	0	0	0	0	0	0	272,408	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	(51,675)	0	0	0	0	0	0	0	0	0	0	(51,675)	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(249,089)	0	0	0	0	0	0	0	0	0	0	(249,089)	43
44	TOTAL Special Cost Centers	(300,764)	0	0	0	0	0	0	0	0	0	0	(300,764)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(270,690)	0	0	0	0	0	0	0	0	0	0	(270,690)	45

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	22 Employee Benefits	\$ 198,299	Carmelite System for the Aged and Inform, Inc.	100.00%	\$ 198,299	\$	1
2	V	26 Insurance	193,183	Carmelite System for the Aged and Inform, Inc.	100.00%	193,183		2
3	V	24 Training		Carmelite System for the Aged and Inform, Inc.	100.00%			3
4	V	22 Health/Dental	35,145	Carmelite System for the Aged and Inform, Inc.	100.00%	35,145		4
5	V	22 Pension	4,632	Carmelite System for the Aged and Inform, Inc.	100.00%	4,632		5
6	V	25 Travel	351	Carmelite System for the Aged and Inform, Inc.	100.00%	351		6
7	V	17 Administrative	148,599	Carmelite System for the Aged and Inform, Inc.	100.00%	148,599		7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 580,209			\$ 580,209	\$ *	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:

01/01/2015

Ending:

12/31/2015

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	Inform, Inc.				for the Aged and Inform, 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

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	9
					Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	SEE BOARD OF DIRECTORS ATTACHMENT							\$		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: 01/01/2015

Ending: 2/31/2015

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 _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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	N/A				\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number

St Patricks Residence

0035006

Report Period Beginning:

01/01/2015

Ending:

12/31/2015

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	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					Monthly Payment Required	Date of Note				Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO									Original	Balance			
	A. Directly Facility Related															
	Long-Term															
1	N/A						\$	\$			\$					
2																
3																
4																
5																
	Working Capital															
6	N/A															
7																
8																
9	TOTAL Facility Related						\$	\$			\$					
	B. Non-Facility Related*															
10																
11																
12																
13																
14	TOTAL Non-Facility Related						\$	\$			\$					
15	TOTALS (line 9+line14)						\$	\$			\$					

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.)

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.				
1. Real Estate Tax accrual used on 2014 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 2015 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:	2010	_____	8	FOR BHF USE ONLY		
	2011	_____	9			
	2012	_____	10			
	2013	_____	11			
	2014	_____	12			
				13	FROM R. E. TAX STATEMENT FOR 2014 \$	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.

2014 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 2014 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 2014.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	<u>This Schedule is N/A</u>	_____	\$ _____	\$ _____
2.	_____	_____	\$ _____	\$ _____
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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:

01/01/2015 Ending:

12/31/2015

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? (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).

None

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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>Facility</u>	<u>7.33 Acres</u>	<u>1987</u>	<u>\$ 638,590</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	<u>7.33 Acres</u>		<u>\$ 638,590</u>	<u>3</u>

Facility Name & ID Number St Patricks Residence

0035006

Report Period Beginning:

01/01/2015

Ending:

12/31/2015

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	210	1989	1989	\$ 7,786,645	\$	25-40	\$ 275,257	\$ 275,257	\$ 7,060,142	4
5		1997	1997	2,194,676		40	54,867	54,867	960,172	5
6		2000	2000	2,987,034		40	74,675	74,675	1,052,189	6
7		2005	2005	894,078		35	26,422	26,422	259,563	7
8										8
	Improvement Type**									
9	Various		1991	4,862		20			4,862	9
10	Various		1993	6,175		20			6,175	10
11	Various		1994	32,324		20	75	75	32,365	11
12	Various		1996	2,976		20			2,976	12
13	Various		1997	52,566		20	2,030	2,030	47,491	13
14	Various		1998	28,215		20	514	514	19,172	14
15	Various		1999	6,832		20			6,832	15
16	Various		2000	16,581		20	829	829	12,021	16
17	Various		2001	10,440		20	522	522	7,047	17
18	Various		2002	3,966		20			3,966	18
19	Various		2005	10,938		20	1,094	1,094	10,392	19
20	Various		2006	226,358		20	18,282	18,282	154,766	20
21	Various		2007	101,740		20	5,177	5,177	38,828	21
22	Various		2008	250,909		20	14,612	14,612	94,979	22
23	Boiler		2009	4,031		20	202	202	1,103	23
24	Repair Coil On roof		2009	3,728		20	186	186	1,116	24
25	Front Entrance Sign		2009	5,288		20	176	176	1,056	25
26	Elevator Final Payment		2009	20,875		20	1,044	1,044	6,264	26
27	Repair 2 Roof Areas		2009	21,077		20	1,054	1,054	6,324	27
28	Firm Pump Repair		2009	3,402		20	170	170	1,020	28
29	Elevator Work		2009	2,500		20	63	63	378	29
30	Wander Prevention System		2009	6,963		20	348	348	2,088	30
31	SS Panels for Kitchen		2009	8,797		20	440	440	2,640	31
32	Replace Furnace New Addition		2009	6,134		20	307	307	1,842	32
33	42 Cornices		2009	6,005		20	300	300	1,800	33
34	Replace Txv Valve / Hallway AC		2009	2,835		20	142	142	852	34
35	Wander Prevention System		2009	8,484		20	424	424	2,544	35
36	Compressor		2009	4,117		20	206		1,236	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:

01/01/2015

Ending:

12/31/2015

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Walk-In-Cooler	2009	\$ 19,874	\$	20	\$ 662	\$ 662	\$ 3,972	37
38	Door Kick Plates	2009	6,060		20	303	303	1,818	38
39	Parts for Walk-In Cooler	2010	5,463		20	273	273	1,365	39
40	Walk-In Cooler	2010	7,951		20	398	398	1,989	40
41	Front Door Roam Alert System	2010	2,559		20	128	128	640	41
42	Air Curtain - Employee Entrance	2010	4,900		20	245	245	1,225	42
43	Booster Water Heater / Blaster Chiller	2010	10,496		20	525	525	2,625	43
44	Backflow Preventer	2010	13,139		20	657	657	3,285	44
45	Sprinkler Heads in Elevator	2010	4,630		20	232	232	1,159	45
46	Roofing Repairs	2010	8,500		20	425	425	2,125	46
47	A/C Pipes & Valves	2010	6,054		20	303	303	1,514	47
48	Walk-In Cooler	2010	17,593		20	880	880	4,399	48
49	Landscaping	2010	4,500		20	225	225	1,125	49
50	Roof Top Garden / Patio	2010	7,645		20	382	382	1,528	50
51	Air Curtain	2011	4,650		20	233	233	932	51
52	Security System - Employee Entrance	2011	8,245		20	412	412	1,648	52
53	Lobby A/C	2011	2,846		20	142	142	568	53
54	Lobby Compressor	2011	5,160		20	258	258	1,032	54
55	Privacy Curtains / Cornices	2011	11,956		20	598	598	2,392	55
56	Security System - Employee Entrance	2011	8,284		20	414	414	1,656	56
57	Roof Top Garden / Patio	2011	2,500		20	125	125	500	57
58	Roof Top Garden / Patio	2011	49,072		20	2,454	2,454	9,816	58
59	Roof Top Garden / Patio	2011	61,692		20	3,085	3,085	12,340	59
60	Back Door	2011	3,800		20	190	190	760	60
61	Concrete - Compactor Base Pad	2011	2,850		20	143	143	572	61
62	Roof Replacement	2011	19,700		20	985	985	3,940	62
63	Amex/Wet - Glycol for Heating System	2012	2,573		20	129	129	387	63
64	Amex/Chemicals for A/C System	2012	2,578		20	129	129	387	64
65	Wm F. Meyer - Sewer Rodder - Amex	2012	2,620		20	131	131	393	65
66	Chase/Classic Fence - Fence for Compactor	2012	2,768		20	138	138	414	66
67	Robert Gill & Co. - Shelving	2012	2,904		20	145	145	435	67
68	Amex/Sun Ray Heating - Repair Boiler Coil	2012	2,950		20	148	148	444	68
69									69
70	TOTAL (lines 4 thru 69)		\$ 15,038,063	\$		\$ 494,915	\$ 494,709	\$ 9,871,586	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:

01/01/2015

Ending:

12/31/2015

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	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 15,038,063	\$		\$ 494,915	\$ 494,915	\$ 9,871,586	1
2	Amex/Break Room Flooring	2012	3,507		20	175	175	525	2
3	RJKeck Piping/Install PVC	2012	4,609		20	230	230	690	3
4	Metro Tank and Pump Co/Instl 300 Gal Tank	2012	5,000		20	250	250	750	4
5	Accelerated Care Plus Corp - Omnicycle Rehab System	2012	6,096		20	305	305	915	5
6	Chase/Replace HVAC Unit	2012	6,305		20	315	315	945	6
7	Metro Tank - Diesel Fuel Tank	2012	10,869		20	543	543	1,629	7
8	Precision Cntrl/Chase - Piping & Valve System	2012	11,355		20	568	568	1,704	8
9	Amex/Neuco - HVAC Air Handler	2012	14,323		20	716	716	2,148	9
10	Chase/Great Lakes Paving - Blacktop Front & Convent	2012	18,765		20	938	938	2,814	10
11	Great Lakes Paving - Resurface Front Lot/Circle	2012	21,600		20	1,080	1,080	3,240	11
12	Showalter Roofing Service Inc - Roof Repairs	2012	22,710		20	1,136	1,136	3,408	12
13	Great Lakes Paving - Paving	2013	14,175		20	1,418	1,418	3,544	13
14	Amex/Showalter Roofing - Roof Repair	2013	3,720		10	371	371	929	14
15	Chase/Showalter Roofing - Partial Roof Replacement	2013	2,560		10	256	256	640	15
16	Jim Wagner Plumbing - 2 Copper Hot Water Supply	2013	3,394		10	339	339	848	16
17	Amex/West Side Mech - Fire Dampers	2013	4,200		10	420	420	1,050	17
18	Gilkinson Masonry - Tuckpoint Block Walls	2013	12,760		10	1,276	1,276	3,190	18
19	Lowery Tiel	2013	5,092		10	509	509	1,273	19
20	Chase/Thermo Heat Exchanger Cleaning system	2013	3,422		5	684	684	1,711	20
21	Clost Designs & More - Coffee Shop Cabinets	2013	2,600		10	260	260	650	21
22	Edot - Install Surveillance Cameras	2013	3,000		10	300	300	750	22
23	Edot - Parking Lot Cameras	2013	3,120		10	312	312	780	23
24	Amex/Century Tile - Coffee Shop Tile - Guild	2013	3,023		10	302	302	755	24
25	Roseland Draperies - 2E/2W Cornices/Shades	2013	7,377		10	738	738	1,845	25
26	Amex/H-Mac Gas Duct Furnace	2013	3,188		10	319	319	797	26
27	Amex/West USA Ethylene Glycol 4-55 gal	2013	2,889		10	289	289	722	27
28	Entegra Procurement Svcs - Air Curtain Refrigerator	2013	10,976		10	1,098	1,098	2,744	28
29	Financial Statement Depreciation	2014							29
30	Ashland Door solutions	2014	11,627		20	581	581	1,162	30
31	Madden Glass/event room & 4 office Windows	2014	22,360		15	1,491	1,491	2,982	31
32	Madden Glass/ 16 Winvent screens	2014	1,317		15	88	88	176	32
33	Precision Piping for 1west heating/cooling		2,950		15	494	494	988	33
34	TOTAL (lines 1 thru 33)		\$ 15,286,952	\$		\$ 512,716	\$ 512,716	\$ 9,917,890	34

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

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	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 15,286,952	\$		\$ 512,716	\$ 512,716	\$ 9,917,890	1
2	Chapel Heat Exchanger	2014	10,250		15	342	342	684	2
3	Inpro Elevator Update	2015	8,259		10	413	413	413	3
4	Inpro Elevator Update	2015	6,246		10	312	312	312	4
5	Ashland Door solutions 1st half 2nd &3rd flo fire doors	2015	18,626		10	931	931	931	5
6	Ashland door solutions 2nd half 2nd&3rd flr fire doors	2015	21,371		20	534	534	534	6
7	Westside Mechanical	2015	5,116		15	171	171	171	7
8	Reliant Electrocal Electric for AC	2015	2,758		10	138	138	138	8
9	Gilkinson Masonary Convent outside repair	2015	11,410		10	571	571	571	9
10	Westside Mechanical Main Electric Room A/C	2015	18,950		15	632	632	632	10
11	Adler Plumbing & heating Inc/replace wite pipe/mixing valves	2015	15,320		20	383	383	383	11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 15,405,258	\$		\$ 517,143	\$ 517,143	\$ 9,922,659	34

**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	\$ 4,046,466	\$	\$ 200,782	\$ 200,782	10	\$ 3,570,526	71
72	Current Year Purchases	485,014		89,448	89,448	10	89,448	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 4,531,480	\$	\$ 290,230	\$ 290,230		\$ 3,659,974	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		2001 Dodge Grand Caravan	2004	\$ 12,026	\$	\$	\$	5	\$ 12,026	76
77		2008 Chevy Bus	2007	49,512		4,951	4,951	10	40,434	77
78		2008 Silverado Pickup	2008	23,591		2,359	2,359	10	17,693	78
79		See Attached		14,913				10	8,788	79
80	TOTALS			\$ 100,042	\$	\$ 7,310	\$ 7,310		\$ 78,941	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)	\$ 20,675,370	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 814,683	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 814,683	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 13,661,574	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	N/A	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	\$	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 Patricks Residence

0035006

Report Period Beginning: 01/01/2015

Ending: 12/31/2015

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions. YES NO

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

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. _____ /2016 \$ _____

13. _____ /2017 \$ _____

14. _____ /2018 \$ _____

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: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ _____ Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		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.)

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service			Units	Cost					
1	Licensed Occupational Therapist	39-3	hrs	\$		\$	275,959	\$		\$	275,959	1
2	Licensed Speech and Language Development Therapist	39-3	hrs				219,285				219,285	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39-3	hrs				511,261				511,261	4
5	Physician Care		visits									5
6	Dental Care		visits									6
7	Work Related Program		hrs									7
8	Habilitation		hrs									8
9	Pharmacy	39-2	# of prescripts					282,556			282,556	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Other (specify): <u>See Supplemental</u>	39-2						45,242			45,242	12
13	Other (specify):											13
14	TOTAL			\$		\$	1,006,505	\$	327,798	\$	1,334,303	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: 01/01/2015

Ending:

12/31/2015

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2015

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 1,585,737	\$	1
2	Cash-Patient Deposits	14,316		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 397,788)	2,197,040		3
4	Supply Inventory (priced at)	66,356		4
5	Short-Term Investments			5
6	Prepaid Insurance	37,724		6
7	Other Prepaid Expenses	44,950		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Insurance Receivable	36,897		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,983,020	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	638,590		13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	15,237,861		15
16	Equipment, at Historical Cost	5,071,536		16
17	Accumulated Depreciation (book methods)	(13,180,068)		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 (specify):			22
23	Other(specify): See Grouping BS23	7,893,242		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 15,661,161	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 19,644,181	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 525,817	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	14,316		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	417,123		30
31	Accrued Taxes Payable (excluding real estate taxes)	14,154		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	See Grouping BS36	742,080		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,713,490	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,713,490	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 17,930,691	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 19,644,181	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 18,014,672	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 18,014,672	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(83,981)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (83,981)	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)	\$ 17,930,691	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number St Patricks Residence# 0035006Report Period Beginning: 01/01/2015Ending: 12/31/2015

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	\$ 17,381,170	1
2	Discounts and Allowances for all Levels	(4,115,189)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 13,265,981	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,460,784	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,460,784	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	64,439	12
13	Barber and Beauty Care	54,501	13
14	Non-Patient Meals	120	14
15	Telephone, Television and Radio	18,056	15
16	Rental of Facility Space	63,455	16
17	Sale of Drugs	255,340	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	41,418	19
20	Radiology and X-Ray	19,970	20
21	Other Medical Services	595,353	21
22	Laundry	240	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,112,892	23
D. Non-Operating Revenue			
24	Contributions	530,652	24
25	Interest and Other Investment Income***	(47,881)	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 482,771	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	21,272	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 21,272	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 17,343,700	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	3,067,821	31
32	Health Care	8,177,147	32
33	General Administration	3,442,553	33
B. Capital Expense			
34	Ownership	542,275	34
C. Ancillary Expense			
35	Special Cost Centers	1,707,446	35
36	Provider Participation Fee	490,439	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 17,427,681	40
41	Income before Income Taxes (line 30 minus line 40)**	(83,981)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (83,981)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 4,605,832	44
45	Private Pay - Net Inpatient Revenue	7,649,984	45
46	Medicare - Net Inpatient Revenue	890,591	46
47	Other-(specify) <u>Medicare Advantage</u>	121,259	47
48	Other-(specify) <u>Managed Care</u>	(1,685)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 13,265,981	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:

01/01/2015

Ending:

12/31/2015

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	2,040	2,282	\$ 101,322	\$ 44.40	1
2	Assistant Director of Nursing	1,936	1,936	59,179	30.57	2
3	Registered Nurses	60,770	65,694	2,358,109	35.90	3
4	Licensed Practical Nurses	39,798	43,844	1,061,811	24.22	4
5	CNAs & Orderlies	149,423	160,977	2,301,839	14.30	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	9,324	10,311	179,048	17.36	8
9	Activity Director	2,134	2,270	49,556	21.83	9
10	Activity Assistants	19,953	21,659	240,493	11.10	10
11	Social Service Workers	5,963	6,326	335,560	53.04	11
12	Dietician	1,841	1,909	55,878	29.27	12
13	Food Service Supervisor	8,987	9,786	201,549	20.60	13
14	Head Cook	6,020	6,885	129,109	18.75	14
15	Cook Helpers/Assistants	44,244	49,609	511,638	10.31	15
16	Dishwashers	4,615	4,951	50,323	10.16	16
17	Maintenance Workers	10,506	11,823	253,232	21.42	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,148	2,232	104,358	46.76	20
21	Assistant Administrator	2,400	2,496	90,432	36.23	21
22	Other Administrative	2,200	2,264	101,497	44.83	22
23	Office Manager	6,219	6,891	174,513	25.32	23
24	Clerical	19,809	21,094	331,049	15.69	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)	16,042		173,307		33
34	TOTAL (lines 1 - 33)	416,372	435,239	\$ 8,863,802 *	\$ 20.37	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	120	25,200	9-3	36
37	Medical Records Consultant	19	1,110	10-3	37
38	Nurse Consultant	150	13,606	10-3	38
39	Pharmacist Consultant		14,593	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	20	130	10A-3	44
45	Social Service Consultant	13	825	10A-3	45
46	Other(specify) <u>HR Director</u>	61	5,480	21-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	382	\$ 60,944		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	25	\$ 1,032	10-3	50
51	Licensed Practical Nurses	7,520	282,017	10-3	51
52	Certified Nurse Assistants/Aides	35,894	753,774	10-3	52
53	TOTAL (lines 50 - 52)	43,439	\$ 1,036,823		53

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	None	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number St Patricks Residence

0035006

Report Period Beginning:

01/01/2015

Ending:

12/31/2015

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. LEADINGAGE \$9420
- (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. \$ 92,207 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. \$ 490,439
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. \$ 0 Has any meal income been offset against related costs? YES Indicate the amount. \$ 120
- (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? NONE
- d. Have vehicle usage logs been maintained? YES
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? NO**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: CLIFTONLARSONALLEN, LLP
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. YES
Attach invoices and a summary of services for all architect and appraisal fees.