



Facility Name & ID Number Mount St Joseph

# 0005520 Report Period Beginning: 7/1/2016 Ending: 6/30/2017

**III. STATISTICAL DATA**

**A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds \_\_\_\_\_**

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	129	Intermediate/DD	129	47,085	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	129	TOTALS	129	47,085	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				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	39,134	730		39,864	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	39,134	730		39,864	14

**C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.66%**

**D. How many bed reserve days during this year were paid by the Department?**  
None (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

**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 1947

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

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

Medicare Intermediary \_\_\_\_\_

**IV. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 6/30/2017 Fiscal Year: 6/30/2017

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

Facility Name & ID Number Mount St Joseph # 0005520 Report Period Beginning: 7/1/2016 Ending: 6/30/2017

**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
	<b>A. General Services</b>										
1	Dietary	176,051			176,051		176,051	(17,605)	158,446		1
2	Food Purchase		162,653		162,653		162,653	(16,265)	146,388		2
3	Housekeeping	324,645			324,645		324,645		324,645		3
4	Laundry	48,334	3,355		51,689		51,689		51,689		4
5	Heat and Other Utilities			293,665	293,665		293,665	(11,747)	281,918		5
6	Maintenance	197,882	26,847		224,729		224,729		224,729		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	746,912	192,855	293,665	1,233,432		1,233,432	(45,617)	1,187,815		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			36,000	36,000		36,000		36,000		9
10	Nursing and Medical Records	2,719,701	85,864	42,863	2,848,428	(26,634)	2,821,794		2,821,794		10
10a	Therapy	78,314			78,314		78,314		78,314		10a
11	Activities										11
12	Social Services			7,614	7,614		7,614		7,614		12
13	CNA Training					26,634	26,634		26,634		13
14	Program Transportation			40,572	40,572		40,572		40,572		14
15	Other (specify):* <b>Day Training</b>	365,537	20,099	490,813	876,449		876,449	(842,368)	34,081		15
16	<b>TOTAL Health Care and Programs</b>	3,163,552	105,963	617,862	3,887,377		3,887,377	(842,368)	3,045,009		16
	<b>C. General Administration</b>										
17	Administrative	87,750	11,659		99,409	(34,196)	65,213		65,213		17
18	Directors Fees										18
19	Professional Services			166,229	166,229		166,229		166,229		19
20	Dues, Fees, Subscriptions & Promotions			11,071	11,071		11,071		11,071		20
21	Clerical & General Office Expenses	305,926	18,040		323,966		323,966		323,966		21
22	Employee Benefits & Payroll Taxes			669,159	669,159		669,159	(34,081)	635,078		22
23	Inservice Training & Education										23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice										26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	393,676	29,699	846,459	1,269,834	(34,196)	1,235,638	(34,081)	1,201,557		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	4,304,140	328,517	1,757,986	6,390,643	(34,196)	6,356,447	(922,066)	5,434,381		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 Mount St Joseph

#0005520

Report Period Beginning:

7/1/2016

Ending:

6/30/2017

## 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	
	<b>D. Ownership</b>											
30	Depreciation			1,639,659	1,639,659		1,639,659	81,009	1,720,668			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			93,785	93,785		93,785	(93,785)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			240,000	240,000		240,000	(240,000)				34
35	Rent-Equipment & Vehicles					34,196	34,196		34,196			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			1,973,444	1,973,444	34,196	2,007,640	(252,776)	1,754,864			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			348,560	348,560		348,560		348,560			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			348,560	348,560		348,560		348,560			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	4,304,140	328,517	4,079,990	8,712,647		8,712,647	(1,174,842)	7,537,805			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 Mount St Joseph

# 0005520

Report Period Beginning:

7/1/2016

Ending:

6/30/2017

**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				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$		\$	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	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

Mount St Joseph

ID# 0005520

Report Period Beginning: 7/1/2016

Ending: 6/30/2017

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1		\$		1
2				2
3	Governmental Sponsored Programs	(33,870)	K1 & K2	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	Developmental Day Training	(842,368)	K15	23
24	Payroll Tax Day Training	(34,081)	K22	24
25				25
26				26
27				27
28				28
29	Utilities	(11,747)	K5	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	<b>Total</b>	(922,066)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Mount St Joseph# 0005520

Report Period Beginning:

7/1/2016

Ending:

6/30/2017

## 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	(17,605)	0	0	0	0	0	0	0	0	0	0	(17,605)	1
2	Food Purchase	(16,265)	0	0	0	0	0	0	0	0	0	0	(16,265)	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	(11,747)	0	0	0	0	0	0	0	0	0	0	(11,747)	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	<b>TOTAL General Services</b>	<b>(45,617)</b>	<b>0</b>	<b>(45,617)</b>	<b>8</b>									
	<b>B. Health Care and Programs</b>													
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):* <b>Day Training</b>	<b>(842,368)</b>	<b>0</b>	<b>(842,368)</b>	<b>15</b>									
16	<b>TOTAL Health Care and Programs</b>	<b>(842,368)</b>	<b>0</b>	<b>(842,368)</b>	<b>16</b>									
	<b>C. General Administration</b>													
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	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	(34,081)	0	0	0	0	0	0	0	0	0	0	(34,081)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(34,081)</b>	<b>0</b>	<b>(34,081)</b>	<b>28</b>									
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(922,066)</b>	<b>0</b>	<b>(922,066)</b>	<b>29</b>									

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Mount St Joseph# 0005520

Report Period Beginning:

7/1/2016

Ending:

6/30/2017

## 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)	
	<b>D. Ownership</b>													
30	Depreciation	0	81,009	0	0	0	0	0	0	0	0	0	81,009	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	(93,785)	0	0	0	0	0	0	0	0	0	(93,785)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(240,000)	0	0	0	0	0	0	0	0	0	(240,000)	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	<b>TOTAL Ownership</b>	0	(252,776)	0	0	0	0	0	0	0	0	0	(252,776)	37
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	0	0	0	0	0	0	0	0	0	0	0	0	44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	(922,066)	(252,776)	0	0	0	0	0	0	0	0	0	(1,174,842)	45

Facility Name & ID Number

Mount St Joseph

# 0005520

Report Period Beginning:

7/1/2016

Ending:

6/30/2017

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
Daughters of St Mary of Providence	100					

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	Rent	\$ 240,000	Daughters of St Mary of Providence		\$	\$ (240,000)	1
2	V	Depreciation	(81,009)	Daughters of St Mary of Providence			81,009	2
3	V	Interest	93,785	Daughters of St Mary of Providence			(93,785)	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		\$ 252,776			\$	\$ *	(252,776) 14

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

Facility Name & ID Number

Mount St Joseph

# 0005520

Report Period Beginning:

7/1/2016

Ending:

6/30/2017

**VII. RELATED PARTIES**

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name &amp; ID Number

Mount St Joseph

# 0005520

Report Period Beginning:

7/1/2016

Ending:

6/30/2017

## 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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Sister Nancy McLennon	Superior	C.E.O.	0.00		84	100.00	Stipend	\$ 58,500	L17C1	1
2	Sister Charleen Badiola	Administrator	Director	0.00		84	100.00	Stipend	29,250	L17C1	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 87,750		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 Mount St Joseph

# 0005520

Report Period Beginning:

7/1/2016

Ending: 5/30/2017

**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					\$	\$		\$	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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number

Mount St Joseph

# 0005520

Report Period Beginning:

7/1/2016

Ending:

6/30/2017

**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		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1	Daughters of St Mary						\$	\$			\$	1						
2	of Providence	X		St Clare Cottage Construction	\$10,000.00	9/12/12	5,835,958	1,530,479	N/A	0.0600	93,785	2						
3												3						
4												4						
5												5						
<b>Working Capital</b>																		
6												6						
7												7						
8												8						
9	<b>TOTAL Facility Related</b>				\$10,000.00		\$ 5,835,958	\$ 1,530,479			\$ 93,785	9						
<b>B. Non-Facility Related*</b>																		
10												10						
11												11						
12												12						
13												13						
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14						
15	<b>TOTALS (line 9+line14)</b>						\$ 5,835,958	\$ 1,530,479			\$ 93,785	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.)

**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 2016 report.

\$ **N/A** **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).

\$ **N/A** **3**

4. Real Estate Tax accrual used for 2017 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.

\$ **Tax Exempt** **7**

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	<b>2012</b>	<b>8</b>
	<b>2013</b>	<b>9</b>
	<b>2014</b>	<b>10</b>
	<b>2015</b>	<b>11</b>
	<b>2016</b>	<b>12</b>

**FOR BHF USE ONLY**

<b>13</b>	FROM R. E. TAX STATEMENT FOR 2016	\$	<b>13</b>
<b>14</b>	PLUS APPEAL COST FROM LINE 5	\$	<b>14</b>
<b>15</b>	LESS REFUND FROM LINE 6	\$	<b>15</b>
<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION	\$	<b>16</b>

**NOTES:**

- Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
- 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.**

## 2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Mount St Joseph COUNTY Lake

FACILITY IDPH LICENSE NUMBER 0005520

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 2016 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 2016.

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

**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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

**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 Mount St Joseph

# 0005520

Report Period Beginning:

7/1/2016

Ending:

6/30/2017

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 168,131 B. General Construction Type: Exterior Brick Frame Brick Number of Stories 2

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).

Blank lines for listing other business entities.

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.

Table with 6 columns: Use, Square Feet, Year Acquired, Cost, and two unlabeled columns. Rows include 'Home' and 'TOTALS'.

Facility Name & ID Number Mount St Joseph

# 0005520

Report Period Beginning:

7/1/2016

Ending:

6/30/2017

**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			1969	\$ 5,011,610			\$	\$	\$ 14,058,304
5									
6			1990	2,361,653	78,720		78,720		2,164,802
7			1990	68,729	2,289		2,289		62,968
8									
<b>Improvement Type**</b>									
9			1993	29,005					
10			1994	93,489					
11			1995	44,713					
12			1996	18,082					
13			1997	42,570					
14			1998	17,423					
15			1999	21,853					
16			2001	4,700					
17			2005	22,748					
18			2006	12,917					
19			2007	82,454					
20			1991	74,205					
21			1992	90,293					
22			1993	180,181					
23			1994	178,251					
24			1995	231,228					
25			1996	82,875					
26			1997	71,814					
27			1998	116,448					
28			1999	121,823					
29			2000	37,015					
30			2001	76,812					
31			2002	112,086					
32			2003	250,123					
33			2004	402,099					
34			2005	661,395					
35			2006	964,742					
36			2007	667,688					

\*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 &amp; ID Number Mount St Joseph

# 0005520

Report Period Beginning:

7/1/2016

Ending:

6/30/2017

**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	Land Improvements		\$	\$		\$	\$	\$	37
38	Prior Year	2008	156,512						38
39		2009	157,759						39
40	6 Sandstone Bases & Crosses	11/24/2010	2,922						40
41	Repave Parking Lots	9/6/2012	149,300						41
42	Moselle - sand filter rework for septic system renovation	11/3/2014	45,250						42
43	Everlasting Memorials	2/11/2015	3,509						43
44									44
45									45
46		2008	1,945,635						46
47		2009	351,662						47
48		2010	1,548,258						48
49		2011	455,061						49
50		2012	9,478,660						50
51	Chapel Window Replacement - Payment to NEPCO	1/15/2013	62,000						51
52	Chapel Window Replacement - Payment to NEPCO	1/31/2013	106,832						52
53	Dry Sprinkler Replacement	3/19/2013	15,480						53
54	St Rose Sprinkler Replacement	3/19/2013	4,500						54
55	Chapel Window Replacement - Payment to NEPCO	3/31/2013	152,855						55
56	Chapel Heater Replacement	4/3/2013	5,100						56
57	Decorative Pole Light	5/3/2013	2,600						57
58	Chapel Renovation - Payment to NEPCO	10/31/2013	147,308						58
59	Priest House Renovation	1/23/2014	40,000						59
60	Priest House Light Pole and Fixture	1/29/2014	5,100						60
61	Guanelia Hall Renovation	2/3/2014	4,569,130						61
62	Chairs and Tables	2/7/2014	5,950						62
63	Ceiling Fixtures and Lights	3/10/2014	1,269						63
64	Shielding Cable & Annunciators	3/12/2014	3,820						64
65	Annunciator Panel and Lock	3/28/2014	1,620						65
66	Roof Replacement	7/9/2014	3,995						66
67	Angel Guardian Roofing	7/10/2014	36,450						67
68	Angel Guardian Roofing	7/11/2014	36,527						68
69	Chapel Bathroom Renovation	7/31/2014	5,500						69
70	TOTAL (lines 4 thru 69)		\$ 31,651,588	\$ 81,009		\$ 81,009	\$	\$ 16,286,074	70

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

Facility Name &amp; ID Number Mount St Joseph

# 0005520

Report Period Beginning:

7/1/2016

Ending:

6/30/2017

## 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	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 31,651,588	\$ 81,009		\$ 81,009	\$	\$ 16,286,074	1
2	Boiler Replacement	10/27/2014	8,260						2
3	Campus Network Infrastructure Installation	9/14/2015	133,478						3
4	Nursing Station Windows	10/2/2015	47,282						4
5	Gazebo Screens	10/7/2015	11,250						5
6	St Joseph Hall Renovation	10/25/2015	5,687,799						6
7	NEPCO - Asphalt Repair & Sealing	11/10/2015	154,000						7
8	Campus Network Infrastructure Installation	11/25/2015	106,782						8
9	Heat Exchangers	1/29/2016	10,600						9
10	Campus Network Infrastructure Installation	2/15/2016	25,792						10
11	EM Lighting	4/5/2016	9,750						11
12	Nelson Fire Protection - Sacred Heart Sprinklers	4/8/2016	4,462						12
13	Tabernacle Refinish	4/22/2016	1,656						13
14	NEPCO - Water Level Monitor	5/2/2016	3,200						14
15	NEPCO - Conduit Repairs and Replacement	5/4/2016	42,000						15
16	NEPCO - EM Lighting for St Clare	5/10/2016	14,950						16
17	Everlasting Memorial Crosses	7/1/2016	3,509						17
18	Large Chimney Renovation	7/5/2016	63,628						18
19	Fish Lake Cedar Fence	7/27/2016	2,270						19
20	New Well	8/31/2016	672,520						20
21	Therapy Building roof and HVAC	11/30/2016	1,950,941						21
22	Heat Exchanger Replacement	3/30/2017	9,000						22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 40,614,717	\$ 81,009		\$ 81,009	\$	\$ 16,286,074	34

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

Facility Name & ID Number Mount St Joseph

# 0005520

Report Period Beginning:

7/1/2016

Ending:

6/30/2017

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	\$ 2,365,152	\$ 84,817	\$ 84,817	\$		\$ 1,707,462	71
72	Current Year Purchases	56,775						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 2,421,927	\$ 84,817	\$ 84,817	\$		\$ 1,707,462	75

D. Vehicle Costs. (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 43,044,644	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 165,826	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 165,826	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)	\$ 17,993,536	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	Farm Equipment	\$ 40,316	\$	\$ 40,316	86
87	Vehicles	443,443	34,107	242,935	87
88	Non-Care	1,134,636	8,349	1,082,731	88
89					89
90					90
91	TOTALS	\$ 1,618,395	\$ 42,456	\$ 1,365,982	91

G. Construction-in-Progress

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

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

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

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: \_\_\_\_\_

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	<b>TOTAL</b>				\$			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.	_____ /2018	\$ _____
13.	_____ /2019	\$ _____
14.	_____ /2020	\$ _____

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: \$ 34,196 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	<b>TOTAL</b>		\$	\$	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.

**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.)**

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input 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. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA <u>40</u></p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA <u>80</u></p>
--	--	---

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility			
		1	2	3	4
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)		8,878		8,878
4	Clinical Wages (b)		17,756		17,756
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	<b>TOTALS</b>	\$	\$ 26,634	\$	\$ 26,634
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$	26,634		

**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	23
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	<b>23</b>

- (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	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	L9, C3	12 visits	36,000				12	36,000	5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): _____									13
14	TOTAL			\$ 36,000		\$	\$	12	\$ 36,000	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.

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 1,319,785	\$ 1,319,785	1
2	Cash-Patient Deposits	88,411	88,411	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>26,000</u> )	1,967,273	1,967,273	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	67,483	67,483	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Interst in Trust - Current</u>	2,149,605	2,149,605	9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 5,592,557	\$ 5,592,557	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	15,247	15,247	12
13	Land		8,000	13
14	Buildings, at Historical Cost		7,437,391	14
15	Leasehold Improvements, at Historical Cost	23,174,453	34,214,229	15
16	Equipment, at Historical Cost		3,003,419	16
17	Accumulated Depreciation (book methods)		(19,359,518)	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): <u>Interst in Trust - LT</u>	2,047,150	2,047,150	23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 25,236,850	\$ 27,365,918	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 30,829,407	\$ 32,958,475	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 281,599	\$ 281,599	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	88,411	88,411	28
29	Short-Term Notes Payable	120,000	120,000	29
30	Accrued Salaries Payable	216,507	216,507	30
31	Accrued Taxes Payable (excluding real estate taxes)	29,761	29,761	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
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 736,278	\$ 736,278	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	1,410,479	1,410,479	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 1,410,479	\$ 1,410,479	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 2,146,757	\$ 2,146,757	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 28,682,650	\$ 30,811,718	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 30,829,407	\$ 32,958,475	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>27,722,277</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>27,722,277</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>960,373</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>960,373</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>28,682,650</b>	<b>24</b> *

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

**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required**

**classifications of revenue and expense must be provided on this form, even if financial statements are attached.**

**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense**

		1	
I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 5,885,172	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 5,885,172	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	3,220,137	24
25	Interest and Other Investment Income***	9,263	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 3,229,400	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a	<u>Developmental Day Training</u>	558,448	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 558,448	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 9,673,020	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	8,364,087	31
32	Health Care		32
33	General Administration		33
<b>B. Capital Expense</b>			
34	Ownership		34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers		35
36	Provider Participation Fee	348,560	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 8,712,647	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	960,373	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 960,373	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 4,436,132	44
45	Private Pay - Net Inpatient Revenue	106,440	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) <u>SSA/SSI</u>	1,342,600	47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 5,885,172	49

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

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

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

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

Facility Name & ID Number Mount St Joseph

# 0005520

Report Period Beginning:

7/1/2016

Ending:

6/30/2017

**XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)**

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing		\$	\$	1	
2	Assistant Director of Nursing				2	
3	Registered Nurses	19,105	19,793	516,406	26.09	3
4	Licensed Practical Nurses	8,166	8,461	186,301	22.02	4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	3,367	3,488	78,314	22.45	9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	2,022	2,095	38,028	18.15	13
14	Head Cook	7,145	7,403	92,535	12.50	14
15	Cook Helpers/Assistants	4,130	4,279	45,488	10.63	15
16	Dishwashers					16
17	Maintenance Workers	11,654	12,073	197,882	16.39	17
18	Housekeepers	33,622	34,833	324,645	9.32	18
19	Laundry	5,099	5,282	48,334	9.15	19
20	Administrator	4,525	4,688	75,000	16.00	20
21	Assistant Administrator	5,288	5,478	63,000	11.50	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	14,118	14,627	255,676	17.48	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	10,628	11,010	209,084	18.99	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	147,512	152,824	1,807,910	11.83	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>Day Training</u>	28,685	29,718	365,537	12.30	33
34	TOTAL (lines 1 - 33)	305,066	316,052	\$ 4,304,140 *	\$ 13.62	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	127	\$ 6,327	L1, C3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	14	864	L10,C3	45
46	Other(specify) <u>Dentist</u>	56	2,793	L10,C3	46
47	<u>Psychiatrist</u>	23	6,750	L10,C3	47
48					48
49	TOTAL (lines 35 - 48)	219	\$ 16,734		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions			
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount			
Sister Nancy McLennon	Superior		\$ 58,500	Workers' Compensation Insurance	\$ 134,538	IDPH License Fee	\$			
Sister Charleen Badiola	Administrator		29,250	Unemployment Compensation Insurance		Advertising: Employee Recruitment				
				FICA Taxes	327,561	Health Care Worker Background Check				
				Employee Health Insurance	92,861	(Indicate # of checks performed)				
				Employee Meals		Patient Background Checks				
				Illinois Municipal Retirement Fund (IMRF)*		Licenses & Fees	3,927			
				Employee Pension	114,199	Dues & Subscriptions	7,144			
				Day Training Payroll Tax	(23,474)					
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 87,750	TOTAL (agree to Schedule V, line 22, col.8)			\$ 645,685	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 11,071
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**			
Description	Amount			Description	Line #	Amount	Description	Amount		
	\$					\$	Out-of-State Travel	\$ 0		
							In-State Travel	0		
							Seminar Expense	0		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL			\$	Entertainment Expense	( 0 )	
C. Professional Services										
Vendor/Payee	Type	Amount								
AmCheck	Payroll	\$ 21,050					TOTAL (agree to Sch. V, line 24, col. 8)		\$ 0	
BIK & Co	Auditors	30,700								
BT Partners	IT	55,729								
Michael Sullivan	Accounting	58,750								
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 166,229							

\* Attach copy of IMRF notifications

\*\*See instructions.

Facility Name & ID Number Mount St Joseph# 0005520Report Period Beginning: 7/1/2016Ending: 6/30/2017**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No  
If YES, give association name and amount. \_\_\_\_\_
- (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? \_\_\_\_\_
- (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? \_\_\_\_\_
- (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 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 50,017 Line L10
- (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. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 348,560  
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? Yes 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 benefit on Schedule V. \$ N/A Has any meal income been offset against related costs? N/A Indicate the amount. \$ N/A
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? Yes If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 0  
c. What percent of all travel expense relates to transportation of nurses and patients? N/A  
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? Yes  
g. Does the facility transport residents to and from day training? Yes  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: Wipfli 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. N/A  
Attach invoices and a summary of services for all architect and appraisal fees

V. COST CENTER EXPENSES RECLASSIFICATION PAGE 3

FROM V. LINE 10 \$ (26,634)  
 TO V. LINE 13 \$ 26,634  
 TO RECLASSIFY NURSE AIDE TRAINING

FROM V. LINE 17 \$ (34,196)  
 TO V. LINE 35 \$ 34,196  
 TO RECLASSIFY RENT-EQUIPMENT

LINE 15 PAGE 3  
 DAY TRAINING SALARIES \$ 489,198  
 DAY TRAINING SUPPLIES \$ 20,099  
 DAY TRAINING BENEFITS \$ - \$ 23,980  
 DAY TRAINING PROFESSIONAL FEES \$ - \$ 5,662  
 DAY TRAINING OCCUPANCY \$ - \$ 81,996  
 DAY TRAINING OCCUPANCY \$ - \$ 5,272  
 DAY TRAINING RENT \$ - \$ 27,600  
 DAY TRAINING DEPRECIATION \$ - \$ 188,561  
 DAY TRAINING EDUCATIONAL \$ - \$ -  
 DAY TRAINING SUB-TOTAL \$ - \$ 842,368  
 DAY TRAINING P/R TAX LINE 22 PAGE 3 \$ 34,081  
 TOTAL \$ 876,449

VI. ADJUSTMENT DETAIL PAGE 5

NON-ALLOWABLE EXPENSES

DIETARY VI. LINE 1 X .10 = \$ 17,605 \$ 33,870  
 FOOD PURCHASE V. LINE 2 X .10 = \$ 16,265 \$ 81,009  
 DEPRECIATION V. LINE 30 \$ 842,368  
 DAY TRAINING V. LINE 15 \$ 34,081  
 DAY TRAINING P/R TAX V. LINE 22 \$ 11,747  
 UTILITIES V. LINE 5 \$ 1,003,075

SUB-TOTAL (A): \$ 1,003,075

RELATED PARTIES VII. LINE 14 \$ -

TOTAL ADJUSTMENTS (A) AND (B) \$ 1,003,075

V. ADJUSTMENT DETAIL/UTILITIES PAGE 5 SQUARE FOOTAGE

CARE RELATED AREAS:

THERAPEUTIC CENTER 22,122  
 JOSEPH,S 9,464  
 OLD NURSES STATION TO KITCHEN PASSAGEWAY 6,770  
 PASSAGEWAY 6,947  
 ADMINISTRATIVE BUILDING 6,890  
 ST. ALYIOUS 9,270  
 NOVITIATE & AUDITORIUM 11,120  
 GUANELLA 15,887  
 ANGEL GUARDIAN 9,582  
 KITCHEN 5,749  
 BOILER & LAUNDRY 4,690  
 GARAGE 660  
 CHAPEL 12,468  
 CHAPLAIN,S HOUSE 4,022  
 GARAGE 1,012  
 ADMON BUILDING 2nd FLOOR 3,445  
 ST. MARY,S 11,691  
 ST. CLAIR,S 19,014

TOTAL.. 160,803

NON-CARE RELATED AREAS:

NOVITIATE & AUDITORIUM 5,560  
 FARM HOUSE 1,768

TOTAL 7,328

TOTAL SQUARE FOOTAGE 168,131

NON-CARE AREAS 7,328/168,131 .04

TOTAL UTILITIES LINE 5 PAGE 3 \$ 293,665

TOTAL NON-CARE RELATED UTILITIES \$ 11,747

XVII. INCOME STATEMENT OTHER REVENUE PAGE 19 \$ 9,673,020

DEVELOPMENTAL DAY TRAINING LINE 28a \$ 558,448

XVIII. A. STAFFING & SALARY COSTS PAGE 20 \$ 4,304,140

DEVELOPMENTAL DAY TRAINING LINE 33 \$ 365,537

XX. GENERAL INFORMATION PAGE 23

COST ASSOCIATED WITH SPACE RENTAL LINE (14) NUNS QUARTERS