

		FOR BHF USE					

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: <u>0020495</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Brother James Court</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>7/1/15</u> to <u>6/30/16</u> and certify to the best of my knowledge and belief that the said content: are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge	
Address: <u>2508 St James Road</u> <u>Springfield</u> <u>62707</u> Number City Zip Code		Intentional misrepresentation or falsification of any informatior in this cost report may be punishable by fine and/or imprisonment	
County: <u>Sangamon</u>			
Telephone Number: <u>217-544-4676</u> Fax # <u>217-474-5914</u>			
HFS ID Number: _____			
Date of Initial License for Current Owners: <u>October 1, 1975</u>			
Type of Ownership:			
☒ VOLUNTARY, NON-PROFIT			
☒ Charitable Corp.			
☐ Trust			
IRS Exemption Code _____			
☐ PROPRIETARY			
☐ Individual			
☐ Partnership			
☐ Corporation			
☐ "Sub-S" Corp.			
☐ Limited Liability Co.			
☐ Trust			
☐ Other _____			
GOVERNMENTAL			
☐ State			
☐ County			
☐ Other _____			
In the event there are further questions about this report, please contact: Name: <u>Glenda Beatty</u> Telephone Number: <u>217-747-5900</u> Email Address: _____		Officer or Administrator of Provider (Signed) _____ (Date) _____ (Type or Print Name) <u>Glenda Beatty</u> (Title) <u>Administrator</u>	
		Paid Preparer (Signed) _____ (Date) _____ (Print Name and Title) <u>Richard Lynch</u> <u>Partner</u> (Firm Name & Address) <u>Sikich LLP</u> <u>3201 West White Oaks Drive</u> (Telephone) <u>217-793-3363</u> Fax # <u>217-862-3529</u>	
		MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	

Facility Name & ID Number Brother James Court# 0020495 Report Period Beginning: 7/1/15 Ending: 6/30/16

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	<u>99</u>	Intermediate (ICF)	<u>99</u>	<u>36,135</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>99</u>	TOTALS	<u>99</u>	<u>36,135</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	<u>30,654</u>	<u>365</u>		<u>31,019</u>	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>30,654</u>	<u>365</u>		<u>31,019</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 85.84%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)
_____F. Does the facility maintain a daily midnight census? YesG. 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 10/1/1975J. 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

MODIFIED
ACCRUAL ☒ CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☐ NO ☐Tax Year: 6/30 Fiscal Year: 6/30
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Brother James Court # 0020495 Report Period Beginning: 7/1/15 Ending: 6/30/16
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	
1	Dietary	226,998	19,982	9,236	256,216		256,216		256,216			1
2	Food Purchase		228,404		228,404		228,404		228,404			2
3	Housekeeping	57,562	19,827		77,389		77,389		77,389			3
4	Laundry	48,665	8,862		57,527		57,527		57,527			4
5	Heat and Other Utilities			160,872	160,872		160,872		160,872			5
6	Maintenance	68,335	57	78,098	146,490		146,490		146,490			6
7	Other (specify):*											7
8	TOTAL General Services	401,560	277,132	248,206	926,898		926,898		926,898			8
9	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,477,401	78,847	23,334	1,579,582		1,579,582		1,579,582			10
10a	Therapy			14,784	14,784		14,784		14,784			10a
11	Activities	41,984			41,984		41,984		41,984			11
12	Social Services	179,322	2,772	7,200	189,294		189,294		189,294			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,698,707	81,619	45,318	1,825,644		1,825,644		1,825,644			16
17	C. General Administration											
17	Administrative	79,643			79,643		79,643	(79,643)				17
18	Directors Fees											18
19	Professional Services			235,711	235,711		235,711		235,711			19
20	Dues, Fees, Subscriptions & Promotions			8,183	8,183		8,183		8,183			20
21	Clerical & General Office Expenses	206,105	23,961	177,769	407,835		407,835		407,835			21
22	Employee Benefits & Payroll Taxes			351,359	351,359		351,359		351,359			22
23	Inservice Training & Education											23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			64,155	64,155		64,155		64,155			26
27	Other (specify):*											27
28	TOTAL General Administration	285,748	23,961	837,177	1,146,886		1,146,886	(79,643)	1,067,243			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,386,015	382,712	1,130,701	3,899,428		3,899,428	(79,643)	3,819,785			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 **Brother James Court**

#0020495

Report Period Beginning:

7/1/15

Ending:

6/30/16

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			162,895	162,895		162,895	98,664	261,559			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			5,933	5,933		5,933		5,933			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			310,500	310,500		310,500	(310,500)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			479,328	479,328		479,328	(211,836)	267,492			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportatior											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			218,185	218,185		218,185		218,185			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			218,185	218,185		218,185		218,185			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,386,015	382,712	1,828,214	4,596,941		4,596,941	(291,479)	4,305,462			45

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

	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	(79,643)	17	25
	Income Taxes and Illinois Personal			
26	Property Replacement Tax			26
27	CNA Training for Non-Employees			27
28	Yellow Page Advertising			28
29	Other-Attach Schedule			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (79,643)		\$ 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
	Amortization of Organization & Pre-Operating Expense		
33	Adjustments for Related Organization Costs (Schedule VII)		33
34	Other- Attach Schedule		34
35	SUBTOTAL (B): (sum of lines 31-35)	\$	35
	(sum of SUBTOTALS		
36	TOTAL ADJUSTMENTS (A) and (B))	\$ (79,643)	36
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			\$		38
39					39
40					40
41					41
42					42
43					43
44					44
45					45
46					46
47			\$		47

Brother James Court

ID# 0020495

Report Period Beginning: 7/1/15

Ending: 6/30/16

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
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
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	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Brother James Court# 0020495

Report Period Beginning:

7/1/15

Ending:

6/30/16

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	(79,643)	0	0	0	0	0	0	0	0	0	0	(79,643)	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	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	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	TOTAL General Administration	(79,643)	0	0	0	0	0	0	0	0	0	0	(79,643)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(79,643)	0	0	0	0	0	0	0	0	0	0	(79,643)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Brother James Court# 0020495

Report Period Beginning:

7/1/15

Ending:

6/30/16

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	0	98,664	0	0	0	0	0	0	0	0	0	98,664	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	(310,500)	0	0	0	0	0	0	0	0	0	(310,500)	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	0	(211,836)	0	0	0	0	0	0	0	0	0	(211,836)	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	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	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(79,643)	(211,836)	0	0	0	0	0	0	0	0	0	(291,479)	45

Facility Name & ID Number

Brother James Court

0020495

Report Period Beginning:

7/1/15

Ending:

6/30/16

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
N/A	N/A	N/A	N/A	Franciscan Brothers of the Holy Cross	Springfield	Religious Order
				Springfield Developmental Center	Springfield	Day training program
				Weber Care Corporation	Springfield	Community living facility

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger	4 Amount	5 Cost to Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
			Item		Name of Related Organization				
1	V	34	Facility Rent	\$ 310,500	Franciscan Brothers of the Holy Cross	100.00%	\$	(310,500)	1
2	V	30	Depreciation		Franciscan Brothers of the Holy Cross	100.00%	\$ 98,664	98,664	2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 310,500			\$ 98,664	\$ * (211,836)	14

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

Facility Name & ID Number

Brother James Court

0020495

Report Period Beginning:

7/1/15

Ending:

6/30/16

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 & ID Number Brother James Court # 0020495 Report Period Beginning: 7/1/15 Ending: 6/30/16

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	Brother Anthony Joseph McC	Mission Effectiveness		None	None	40		Consultant	\$ 17,520	21, I	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	\$ 17,520		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 **Brother James Court**# **0020495**Report Period Beginning: **7/1/15**Ending: **6/30/16**

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number **Brother James Court**# **0020495**

Report Period Beginning:

7/1/15

Ending:

6/30/16

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)**

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

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

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number **Brother James Court**# **0020495**

Report Period Beginning:

7/1/15

Ending:

6/30/16**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 2015 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	2
3. Under or (over) accrual (line 2 minus line 1).			\$	3
4. Real Estate Tax accrual used for 2016 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:	2011		8	
	2012		9	
	2013		10	
	2014		11	
	2015		12	

		FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015	\$		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.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Brother James Court COUNTY Sangamon

FACILITY IDPH LICENSE NUMBER 0020495

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 2015 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 2015.

	(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.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ <u> </u>	\$ <u> </u>

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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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 Brother James Court

0020495

Report Period Beginning:

7/1/15

Ending:

6/30/16

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 47,210 B. General Construction Type: Exterior Brick/stone Frame Steel Number of Stories 1

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

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

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

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

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	3

Facility Name & ID Number Brother James Court

0020495

Report Period Beginning:

7/1/15

Ending:

6/30/16

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	
Bed*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4		1975	1975	\$ 1,003,250	\$	30	\$	\$	1,003,250
5		1996	1996	1,251,493		30	41,716	41,716	813,471
6		1997	1997	1,256,490		30	41,883	41,883	758,543
7									
8									
Improvement Type**									
9	Repave Parking Lot		1986	42,236		10			42,236
10	BJC - Bldg Improvement		1980	16,233		11			16,233
11	BJC - Bldg Improvement		1984	21,419		10			21,419
12	BJC - Bldg Improvement		1987	69,555		10			69,555
13	Insulation		1991	9,175		15			9,175
14	BJC - Steam Line		1985	14,479		10			14,479
15									
16	BJC - Bldg Improvement		1975	19,600		24			19,600
17	BJC - Sidewalk/ Patio		1976	3,545		10			3,545
18	BJC - Bike Rink		1978	2,500		5			2,500
19	BJC - Site Improvement		1979	1,440		26			1,440
20	BJC - Roof		1979	12,166		10			12,166
21	Remodeling		1988	46,656		10			46,656
22	BJC - Water Line		1989	3,166		20			3,166
23	Sewage Treatment Plant		1990	6,411		20			6,411
24	Tank Removal		1991	9,809		10			9,809
25	Parking Lot		1992	10,453		10			10,453
26	Repaving Parking Lot		1994	850		10			850
27	Pump		1994	734		10			734
28	BJC - Site Improvement		1996	3,470		20	174	174	3,354
29	Gate		1999	550		5			550
30	Remodeling		1999	5,773		10			5,773
31	Floor		2000	1,683		7			1,683
32	Roof		2011	6,493		10	649	649	2,651
33	Patio		2011	7,385		10	739	739	3,262
34	Fire Alarm		2011	1,551		10	155	155	620
35	Plastering		2011	31,508		10	3,151	3,151	12,603
36									

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

See Page 12A, Line 70 for total

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

Facility Name & ID Number Brother James Court

0020495

Report Period Beginning:

7/1/15

Ending:

6/30/16

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 Pavement	2011	\$ 6,800	\$	10	\$ 680	\$ 680	\$ 3,003		37
38 Landscaping	2011	7,157		10	716	716	3,221		38
39 Fence	2011	2,375		10	238	238	1,029		39
40 Entrance lighting	2011	11,150		10	1,115	1,115	5,296		40
41 Light Fixtures	2011	1,321		10	132	132	551		41
42 Bell Tower roof	2011	7,960		10	796	796	3,582		42
43 Water line	1998	14,120		20			14,120		43
44 Boiler Room	1993	15,106		20			15,106		44
45 Boiler Room	1994	170,330		20			170,330		45
46 Boiler Room	1992	12,498		20			12,498		46
47									47
48 Total Life Center	1998	122,261		30	4,075	4,075	122,261		48
49 BJC - Improvements	1998	15,712		30	524	524	9,340		49
50									50
51 New Wing	1997	18,883		30	629	629	11,697		51
52 Water line repair	1999	3,102		10			3,102		52
53 BJC -Site Improvements	1999	25,849		20	1,292	1,292	21,110		53
54 leasehold improvement	1985	15,200		10			15,200		54
55 leasehold improvement	1986	19,507		10			19,507		55
56 painting	1987	9,922		3			9,922		56
57 steel doors	1987	6,020		10			6,020		57
58 window	1987	2,013		10			2,013		58
59 emergency generator switch	1988	3,335		10			3,335		59
60 remodel lobby	1989	156,996	5,233	30	5,233		139,116		60
61 bus hut	1989	4,715		15			4,715		61
62 hot water heater	1989	6,721		10			6,721		62
63 transfer switch	1989	1,127		10			1,127		63
64 energy panel	1989	8,633		10			8,633		64
65 roof repair	1990	6,928		10			6,928		65
66 remodeling	1990	6,953	232	30	232		6,065		66
67 overhead door	1990	1,220		10			1,220		67
68 kitchen tanks	1990	3,089		10			3,089		68
69 plaster	1990	1,649		10			1,649		69
70 TOTAL (lines 4 thru 69)		\$ 4,548,726	\$ 5,465		\$ 104,129	\$ 98,664	\$ 3,527,693		70

**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 12A, Carried Forward		\$ 4,548,726	\$ 5,465		\$ 104,129	\$ 98,664	\$ 3,527,693	1
2	plastering	1990	937		10			937	2
3	ceiling	1990	2,970		10			2,970	3
4	office signs	1990	170		10			170	4
5	roof repair	1990	2,200		10			2,200	5
6	leasehold improvement	1990	8,762		10			8,762	6
7	leasehold improvement	1990	11,633		10			11,633	7
8	leasehold improvement	1990	3,250		10			3,250	8
9	chair fabric	1991	25		5			25	9
10	gym seat	1991	44		5			44	10
11	drapes	1991	289		5			289	11
12	drapes	1991	908		5			908	12
13	tile installation	1991	876		10			876	13
14	window	1992	2,750		10			2,750	14
15	cafeteria door	1993	11,918		10			11,918	15
16	plumbing work	1994	6,858		10			6,858	16
17	wall and door repair	1995	2,596		10			2,596	17
18	door	1996	656		10			656	18
19	painting	1996	1,620		3			1,620	19
20	furnace	1996	502		10			502	20
21	grip caps	1996	1,575		5			1,575	21
22	bedding	1996	1,505		3			1,505	22
23	air deflectors	1996	381		3			381	23
24	shower	1996	259		5			259	24
25	remodeling	1996	4,928		10			4,928	25
26	roof repair	1997	798		10			798	26
27	drapes	1997	4,500		5			4,500	27
28	floor	1997	1,722		10			1,722	28
29	drapes	1997	3,153		5			3,153	29
30	floor	1997	4,422		10			4,422	30
31	painting	1997	8,917		10			8,917	31
32	redecorate snack lounge	1999	2,847		5			2,847	32
33	roof repair	1999	846		10			846	33
34	TOTAL (lines 1 thru 33)		\$ 4,643,543	\$ 5,465		\$ 104,129	\$ 98,664	\$ 3,622,510	34

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

Facility Name & ID Number Brother James Court

0020495

Report Period Beginning:

7/1/15

Ending:

6/30/16

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 Totals from Page 12B, Carried Forward		\$ 4,643,543	\$ 5,465		\$ 104,129	\$ 98,664	\$ 3,622,510		1
2 carpet	1999	8,881		5			8,881		2
3 yard sign	1999	2,825		10			2,825		3
4 vinyl wall covering	1999	1,127		10			1,127		4
5 shower room	1999	8,220		10			8,220		5
6 sewer connection	1998	7,438		10			7,438		6
7 tree removal	1999	9,857		10			9,857		7
8 condenser	1999	12,396		10			12,396		8
9 drop rod assembly	1999	6,408		10			6,408		9
10 fencing	1999	3,840		10			3,840		10
11 trees	1999	9,905		10			9,905		11
12 roof repair	2000	2,300		10			2,300		12
13 tile floor	2000	34,740		10			34,740		13
14 glass for windows	2000	2,009		10			2,009		14
15 cabinet	1999	4,520		7			4,520		15
16 electrical	1999	17,410		15			17,410		16
17 sign	1999	900		5			900		17
18 masonry	1999	23,465		15			23,465		18
19 plumbing/heating	1999	31,000		15			31,000		19
20 redmodeling	1999	19,524		15			19,524		20
21 parking lot stripes	2000	1,549		5			1,549		21
22 painting	2000	664		5			664		22
23 ramp	2001	14,387		5			14,387		23
24 painting	2001	8,058		5			8,058		24
25 air curtain	2001	1,812		7			1,812		25
26 receptacles	2001	9,820		5			9,820		26
27 shower room floor	2002	1,123		10			1,123		27
28 boiler	2002	3,960		5			3,960		28
29 drapes	2002	4,200		5			4,200		29
30 architect bathroom	2002	9,863		3			9,863		30
31 sidewalks	2002	810		10			810		31
32 tuckpointing	2002	1,490		10			1,490		32
33 floors for wing	2002	2,688		10			2,688		33
34 TOTAL (lines 1 thru 33)		\$ 4,910,732	\$ 5,465		\$ 104,129	\$ 98,664	\$ 3,889,699		34

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

Facility Name & ID Number Brother James Court# 0020495

Report Period Beginning:

7/1/15

Ending:

6/30/16

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	Totals from Page 12C, Carried Forward		\$ 4,910,732	\$ 5,465		\$ 104,129	\$ 98,664	\$ 3,889,699	1
2	keypad lock	2002	580		10			580	2
3	hot water storage tank	2002	4,409		10			4,409	3
4	doors and frames	2003	3,733		10			3,733	4
5	pole lighting	2003	3,740	249	15	249		3,137	5
6	sink faucet	2004	1,133		7			1,133	6
7	wallpaper	2004	2,358	157	15	157		1,886	7
8	doors	2004	4,987	332	15	332		4,045	8
9	ceiling fan	2004	1,082		7			1,082	9
10	electric work	2004	16,000	1,067	15	1,067		12,800	10
11	alarm	2004	2,204		7			2,204	11
12	parking lot	2004	3,443		10			3,443	12
13	boiler	2004	4,871		7			4,871	13
14	boiler	2004	6,900		7			6,900	14
15	boiler	2004	7,200		7			7,200	15
16	hvac	2004	12,497		7			12,497	16
17	parking lot	2004	74,847	2,495	30	2,495		29,731	17
18	dentist office renovation	2004	57,955	1,932	30	1,932		22,699	18
19	pole light replacement	2004	1,868		7			1,868	19
20	storage room	2004	2,375		7			2,375	20
21	bathroom repair	2005	4,232		5			4,232	21
22	alarm	2005	3,000	75	10	75		3,000	22
23	alarm	2005	3,041	127	10	127		3,041	23
24	roof	2006	22,370	1,119	20	1,119		11,837	24
25	water heater	2006	32,250	1,881	10	1,881		32,250	25
26	boiler	2006	4,611		7			4,611	26
27	bathroom repair	2006	6,959		7			6,959	27
28	generator	2007	2,814		5			2,814	28
29	alarm	2007	3,325	333	10	333		3,021	29
30	new roof	2007	90,882	3,029	30	3,029		27,012	30
31	flood light	2008	945	95	10	95		835	31
32	water heater	2008	71,300	7,130	10	7,130		53,475	32
33	a/c unit	2009	7,934	793	10	793		5,884	33
34	TOTAL (lines 1 thru 33)		\$ 5,376,577	\$ 26,279		\$ 124,943	\$ 98,664	\$ 4,175,263	34

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

Facility Name & ID Number Brother James Court

0020495

Report Period Beginning:

7/1/15

Ending:

6/30/16

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 Totals from Page 12D, Carried Forward		\$ 5,376,577	\$ 26,279		\$ 124,943	\$ 98,664	\$ 4,175,263	1	
2 alarm upgrade	2009	1,240	124	10	124		899	2	
3 power supply for ac	2009	1,443		3			1,443	3	
4 hot water system	2008	5,600	200	7	200		5,600	4	
5 a/c rooftop unit	2009	27,544	2,754	10	2,754		19,281	5	
6 bath room	2009	3,346	478	7	478		3,346	6	
7 seal parking	2009	3,315	474	7	474		3,315	7	
8 repaving track	2009	8,400	1,000	7	1,000		8,400	8	
9 bathroom	2009	44,169	6,310	7	6,310		43,643	9	
10 repave walking path	2009	1,450	207	7	207		1,415	10	
11 brick on garage	2009	12,330	1,233	10	1,233		8,323	11	
12 water piping	2009	12,968	1,853	7	1,853		12,350	12	
13 sewer station	2009	15,375	2,196	7	2,196		14,460	13	
14 extend mains to new pipes	2009	2,787	398	7	398		2,621	14	
15 boiler room roof	2010	15,462	515	30	515		3,221	15	
16 office furniture	2010	14,885		5			14,885	16	
17 light fixture	2010	4,791		5			4,791	17	
18 water heater	2011	16,761	1,676	10	1,676		8,520	18	
19 roof repair	2011	6,804	680	10	680		3,402	19	
20 sewer grinder	2010	23,908	2,391	10	2,391		13,747	20	
21 roof repair	2010	19,800	990	20	990		5,775	21	
22 bathroom tile	2010	1,200	120	10	120		660	22	
23 cabinets	2011	1,867	218	5	218		1,867	23	
24 sidewalk	2010	4,169	417	10	417		2,397	24	
25 drain	2010	3,611	361	10	361		2,167	25	
26 outdoor lighting	2010	4,184	70	5	70		4,184	26	
27 door	2010	4,169	417	10	417		2,467	27	
28 front sidewalk	2010	8,850	885	10	885		5,163	28	
29 front door	2010	11,541	1,154	10	1,154		6,732	29	
30 electric	2010	2,119	212	10	212		1,218	30	
31 seal coat parking	2011	3,500	233	15	233		1,147	31	
32 garage door	2011	6,577	329	20	329		1,617	32	
33 concrete	2011	4,465	298	15	298		1,439	33	
34 TOTAL (lines 1 thru 33)		\$ 5,675,207	\$ 54,472		\$ 153,136	\$ 98,664	\$ 4,385,758	34	

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

Facility Name & ID Number Brother James Court

0020495

Report Period Beginning:

7/1/15

Ending:

6/30/16

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	Totals from Page 12E, Carried Forward		\$ 5,675,207	\$ 54,472		\$ 153,136	\$ 98,664	\$ 4,385,758	1
2	hose and cart	2011	113	11	10	11		55	2
3	sidewalk	2011	8,250	825	10	825		3,987	3
4	garage window	2011	6,875	688	10	688		3,266	4
5	kitchen cabinets	2011	3,980	398	10	398		1,857	5
6	countertops	2011	1,120	56	20	56		261	6
7	alarm video	2012	5,998	600	10	600		2,599	7
8	double door	2012	2,552	170	15	170		737	8
9	drapery	2012	2,564	256	10	256		1,090	9
10	curtain rod	2012	96	10	10	10		41	10
11	window	2012	15,208	1,521	10	1,521		6,083	11
12	cabinets	2011	2,786	186	15	186		851	12
13	curtain	2011	3,006	301	10	301		1,353	13
14	tile removal	2012	5,260	526	10	526		2,016	14
15	floor tile	2012	4,200	420	10	420		1,610	15
16	heat exchanger	2012	15,664	1,044	15	1,044		3,916	16
17	fire sprinkler	2012	44,209	8,842	5	8,842		33,157	17
18	fire alarm system	2013	40,199	8,040	5	8,040		27,470	18
19	fire alarm garage	2013	5,374	1,075	5	1,075		3,314	19
20	golf cart	2014	8,235	1,647	5	1,647		3,569	20
21	5 dell computers	2014	3,725	745	5	745		1,614	21
22	1 dell laptop	2014	1,001	200	5	200		434	22
23	5 dell 23" monitors	2014	975	195	5	195		423	23
24	4 dell 19" monitors	2014	660	132	5	132		275	24
25	tank sump pump	2013	4,396	440	10	440		1,282	25
26	horizantal boiler feed water	2013	15,670	2,239	7	2,239		5,970	26
27	printer	2014	296	59	5	59		123	27
28	printer	2014	296	59	5	59		123	28
29	fire alarm plant service	2013	9,133	1,827	5	1,827		4,566	29
30	smoke detector	1998	20,108		5			20,108	30
31	boiler	1996	3,335		10			3,335	31
32	door repair	2002	6,197		10			6,197	32
33	drapery	2001	10,881		5			10,881	33
34	TOTAL (lines 1 thru 33)		\$ 5,927,569	\$ 86,984		\$ 185,648	\$ 98,664	\$ 4,538,321	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 12F, Carried Forward		\$ 5,927,569	\$ 86,984		\$ 185,648	\$ 98,664	\$ 4,538,321	1
2	floor	1997	2,658		7			2,658	2
3	land improvements	1996	1,385		3			1,385	3
4	landscaping	1999	18,255		10			18,255	4
5	leasehold improvements	2003	5,754		5			5,754	5
6	leasehold improvements	1999	2,598		5			2,598	6
7	leasehold improvements	1990	6,629		10			6,629	7
8	new valves	1999	11,685		10			11,685	8
9	painting	1995	3,076		10			3,076	9
10	painting	2000	6,352		5			6,352	10
11	parking lot security system	2005	20,404		7			20,404	11
12	repairs	1996	10,702		5			10,702	12
13	roof repairs	1996	5,985		10			5,985	13
14	sewer	1996	9,387		10			9,387	14
15	strip and refinish floors	2002	8,702		10			8,702	15
16	toilet room addition	2004	699,826	23,328	30	23,328		292,308	16
17	Parking lot light	2014	5,380	359	15	359		687	17
18	B&G Electric Pump	2014	644	43	15	43		82	18
19	Nurse Door Alarm	2015	13,343	890	15	890		1,186	19
20	Door Alarm	2015	11,764	784	15	784		980	20
21	Door Alarm	2015	17,867	1,189	15	1,189		1,387	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)		\$ 6,789,965	\$ 113,577		\$ 212,241	\$ 98,664	\$ 4,948,523	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	\$ 272,097	\$ 32,146	\$ 32,146		various	\$ 150,346	71
72	Current Year Purchases	69,395	7,562	7,562		various	7,562	72
73	Fully Depreciated Assets	1,770,808				various	1,770,808	73
74								74
75	TOTALS	\$ 2,112,300	\$ 39,708	\$ 39,708			\$ 1,928,716	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	Facility Use	Trucks	various	\$ 9,500	\$ 1,900	\$ 1,900		5	\$ 8,550	76
77	Resident Transportation	Vans	various	55,071	7,714	7,714		5	42,820	77
78	Resident Transportation	Auto - Fully Depreciated	various	138,521				5	138,521	78
79										79
80	TOTALS			\$ 203,092	\$ 9,614	\$ 9,614			\$ 189,891	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)	\$ 9,105,357	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 162,899	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 261,563	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 98,664	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 7,067,130	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

☐ YES
 ☒ NO

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

**

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

9. Option to Buy:

☐ YES
 ☒ NO

 Terms:

 *

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:
 \$ **None**
 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

10. Effective dates of current rental agreement:

Beginning **1975**

Ending **2019**

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

	Fiscal Year Ending	Annual Rent
12.	/2017	\$ 310,500
13.	/2018	\$ 310,500
14.	/2019	\$ 310,500

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

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

Facility Name & ID Number Brother James Court # 0020495 Report Period Beginning: 7/1/15 Ending: 6/30/16
 XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? ☒ YES ☐ NO If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM ☒ IN OTHER FACILITY ☐ COMMUNITY COLLEGE ☐ HOURS PER CNA <u>40</u>	3. CLINICAL PORTION: IN-HOUSE PROGRAM ☒ IN OTHER FACILITY ☐ HOURS PER CNA <u>80</u>
--	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		1		2		3	4
		Facility					
		Drop-outs	Completed	Contract		Total	
1	Community College Tuition	\$		\$		\$	
2	Books and Supplies		427			427	
3	Classroom Wages (a)		3,657			3,657	
4	Clinical Wages (b)		4,546			4,546	
5	In-House Trainer Wages (c)		4,373			4,373	
6	Transportation						
7	Contractual Payments						
8	CNA Competency Tests						
9	TOTALS	\$	13,003	\$		\$	13,003
10	SUM OF line 9, col. 1 and 2 (e)	\$	13,003				

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	20
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	20

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$			1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# 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			\$		\$	\$		\$	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.

XV. BALANCE SHEET - Unrestricted Operating Fund.

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

	1	2	
	Operating	After Consolidation*	
A. Current Assets			
1 Cash on Hand and in Banks	\$ 440,687	\$	1
2 Cash-Patient Deposits			2
3 Accounts & Short-Term Notes Receivable-Patients (less allowance)	437,463		3
4 Supply Inventory (priced at)			4
5 Short-Term Investments	522,097		5
6 Prepaid Insurance			6
7 Other Prepaid Expenses	33,098		7
8 Accounts Receivable (owners or related parties)			8
9 Other(specify):			9
TOTAL Current Assets			
10 (sum of lines 1 thru 9)	\$ 1,433,345	\$	10
B. Long-Term Assets			
11 Long-Term Notes Receivable			11
12 Long-Term Investments	2,004,593		12
13 Land			13
14 Buildings, at Historical Cost			14
15 Leasehold Improvements, at Historical Cos	2,483,557		15
16 Equipment, at Historical Cost	2,287,630		16
17 Accumulated Depreciation (book methods)	(3,774,699)		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):			23
TOTAL Long-Term Assets			
24 (sum of lines 11 thru 23)	\$ 3,001,081	\$	24
TOTAL ASSETS			
25 (sum of lines 10 and 24)	\$ 4,434,426	\$	25

	1	2	
	Operating	After Consolidation*	
C. Current Liabilities			
26 Accounts Payable	\$ 473,448	\$	26
27 Officer's Accounts Payable			27
28 Accounts Payable-Patient Deposits			28
29 Short-Term Notes Payable			29
30 Accrued Salaries Payable	76,172		30
31 Accrued Taxes Payable (excluding real estate taxes)			31
32 Accrued Real Estate Taxes(Sch.IX-B)			32
33 Accrued Interest Payable			33
34 Deferred Compensation			34
35 Federal and State Income Taxes			35
Other Current Liabilities(specify):			
36 Accrued Vacation	104,073		36
37 Accrued Pension	19,500		37
TOTAL Current Liabilities			
38 (sum of lines 26 thru 37)	\$ 673,193	\$	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
TOTAL Long-Term Liabilities			
45 (sum of lines 39 thru 44)	\$	\$	45
TOTAL LIABILITIES			
46 (sum of lines 38 and 45)	\$ 673,193	\$	46
TOTAL EQUITY(page 18, line 24)	\$ 3,761,233	\$	47
TOTAL LIABILITIES AND EQUITY			
48 (sum of lines 46 and 47)	\$ 4,434,426	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1	
		Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 4,602,298	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 4,602,298	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(841,065)	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)	\$ (841,065)	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)	\$ 3,761,233	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Brother James Court

0020495

Report Period Beginning:

7/1/15

Ending:

6/30/16

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	\$ 3,597,034	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,597,034	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	15,280	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	13,472	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 28,752	23
	D. Non-Operating Revenue		
24	Contributions	125,134	24
25	Interest and Other Investment Income***	(19,728)	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 105,406	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc Income	14,279	28
28a	Gain on Sale of Asset	10,405	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 24,684	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,755,876	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	926,898	31
32	Health Care	1,825,644	32
33	General Administration	1,146,886	33
	B. Capital Expense		
34	Ownership	479,328	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	218,185	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,596,941	40
41	Income before Income Taxes (line 30 minus line 40)**	(841,065)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (841,065)	43

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

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

** Does this agree with taxable income (loss) per Federal Income

Tax Return? If not, please attach a reconciliation.

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

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

Facility Name & ID Number Brother James Court

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	2,152	2,152	\$ 62,874	\$ 29.22	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses	21,413	21,413	406,588	18.99	4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	3,137	3,137	41,984	13.38	9
10	Activity Assistants					10
11	Social Service Workers	2,052	2,052	48,087	23.43	11
12	Dietician					12
13	Food Service Supervisor	2,066	2,066	31,958	15.47	13
14	Head Cook					14
15	Cook Helpers/Assistants	19,722	19,722	195,040	9.89	15
16	Dishwashers					16
17	Maintenance Workers	4,022	4,022	68,335	16.99	17
18	Housekeepers	5,375	5,375	57,562	10.71	18
19	Laundry	4,060	4,060	48,665	11.99	19
20	Administrator	2,080	2,080	79,643	38.29	20
21	Assistant Administrator					21
22	Other Administrative	12,244	12,244	206,105	16.83	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	7,953	7,953	131,235	16.50	28
29	Resident Services Coordinator	2,080	2,080	45,080	21.67	29
30	Habilitation Aides (DD Homes)	85,407	85,407	935,772	10.96	30
31	Medical Records	2,129	2,129	27,087	12.72	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	175,892	175,892	\$ 2,386,015 *	\$ 13.57	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	various	\$ 9,236	1, 3	35
36	Medical Director				36
37	Medical Records Consultant	various	23,334	10, 3	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	various	7,200	12, 3	45
46	Other(specify)				46
47	Psychologist Consultant	various	14,784	10a, 3	47
48					48
49	TOTAL (lines 35 - 48)		\$ 54,554		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

Facility Name & ID Number

Brother James Court

STATE OF ILLINOIS

0020495

Report Period Beginning:

7/1/15

Page 21

Ending: 6/30/16

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	Ownership %	Amount
Glenda Beatty	Administrator	0	\$ 79,643
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 79,643

B. Administrative - Other	
Description	Amount
	\$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	\$

C. Professional Services		
Vendor/Payee	Type	Amount
Sikich	Audit/Accounting	\$ 33,144
Legal	Legal	189,592
INB	Trust/Fudiciary Fees	8,993
Illinois Health Care Assoc	Advocacy	3,982
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		\$ 235,711

D. Employee Benefits and Payroll Taxes		
Description	Amount	
Workers' Compensation Insurance	\$ 79,932	
Unemployment Compensation Insurance	61,624	
FICA Taxes	179,359	
Employee Health Insurance		
Employee Meals		
Illinois Municipal Retirement Fund (IMRF)*		
Life Insurance	12,606	
401K Contribution	7,540	
Continuing Education	2,866	
Staff Recognition	242	
Employee Physical	7,190	
TOTAL (agree to Schedule V, line 22, col.8)	\$ 351,359	

E. Schedule of Non-Cash Compensation Paid to Owners or Employees		
Description	Line #	Amount
		\$
TOTAL		\$

F. Dues, Fees, Subscriptions and Promotions	
Description	Amount
IDPH License Fee	\$
Advertising: Employee Recruitment	3,484
Health Care Worker Background Check	891
(Indicate # of checks performed)	
Patient Background Checks	
Dues and Subscription	3,808
Less: Public Relations Expense	()
Non-allowable advertising	()
Yellow page advertising	()
TOTAL (agree to Sch. V, line 20, col. 8)	\$ 8,183

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

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number **Brother James Court**# **0020495**

Report Period Beginning:

7/1/15

Ending:

6/30/16**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political 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
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 Line
- (7) Have all costs reported on this form been determined using accounting procedure 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. \$ 218,185
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 benefit on Schedule V. \$ None 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? Yes
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. \$ 13,472
c. What percent of all travel expense relates to transportation of nurses and patients? 100
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? No
Firm Name:
- (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