

		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: 0050724

Facility Name: St Claras Manor

Address: 200 Fifth Street Lincoln 62656
Number City Zip Code

County: Logan

Telephone Number: 217-735-1507 Fax # ()

HFS ID Number:

Date of Initial License for Current Owners: 2010

Type of Ownership:

☒ VOLUNTARY, NON-PROFIT
☒ Charitable Corp.
☐ Trust
IRS Exemption Code 501

☐ 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: Dave Underwood Telephone Number: 309 823-7135
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/16 to 12/31/16 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or
Administrator
of Provider

(Signed) _____ (Date) _____
(Type or Print Name) David M Underwood
(Title) EVP & CFO

Paid
Preparer

(Signed) _____ (Date) _____
(Print Name and Title) _____
(Firm Name & Address) _____
(Telephone) () Fax # ()

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

Facility Name & ID Number St Claras Manor

0050724 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	<u>140</u>	Skilled (SNF)	<u>140</u>	<u>51,240</u>	<u>1</u>
2		Skilled Pediatric (SNF/PED)			<u>2</u>
3		Intermediate (ICF)			<u>3</u>
4		Intermediate/DD			<u>4</u>
5		Sheltered Care (SC)			<u>5</u>
6		ICF/DD 16 or Less			<u>6</u>
7	<u>140</u>	TOTALS	<u>140</u>	<u>51,240</u>	<u>7</u>

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	<u>17,857</u>	<u>8,593</u>	<u>1,771</u>	<u>28,221</u>	<u>8</u>
9	SNF/PED					<u>9</u>
10	ICF					<u>10</u>
11	ICF/DD					<u>11</u>
12	SC					<u>12</u>
13	DD 16 OR LESS					<u>13</u>
14	TOTALS	<u>17,857</u>	<u>8,593</u>	<u>1,771</u>	<u>28,221</u>	<u>14</u>

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 55.08%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 2010

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 1,771

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: _____ Fiscal Year: _____

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

Facility Name & ID Number St Claras Manor # 0050724 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	
	A. General Services											
1	Dietary	274,340	8,946		283,286		283,286		283,286			1
2	Food Purchase		233,192		233,192		233,192		233,192			2
3	Housekeeping	127,364	22,480		149,844		149,844		149,844			3
4	Laundry	64,516	14,021		78,537		78,537		78,537			4
5	Heat and Other Utilities			102,485	102,485		102,485		102,485			5
6	Maintenance	42,551	78,357	79,641	200,549		200,549		200,549			6
7	Other (specify):*											7
8	TOTAL General Services	508,771	356,996	182,126	1,047,893		1,047,893		1,047,893			8
	B. Health Care and Programs											
9	Medical Director			24,976	24,976		24,976		24,976			9
10	Nursing and Medical Records	1,565,914	192,302	247,576	2,005,792		2,005,792		2,005,792			10
10a	Therapy		164,907	21,597	186,504	(185,758)	746		746			10a
11	Activities	67,214	5,651		72,865		72,865		72,865			11
12	Social Services	44,050	17	3,772	47,839		47,839		47,839			12
13	CNA Training	5,506	205		5,711		5,711		5,711			13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,682,684	363,082	297,921	2,343,687	(185,758)	2,157,929		2,157,929			16
	C. General Administration											
17	Administrative	77,183			77,183		77,183		77,183			17
18	Directors Fees											18
19	Professional Services			278,336	278,336		278,336	(16,535)	261,801			19
20	Dues, Fees, Subscriptions & Promotions			291,938	291,938	(240,413)	51,525	(30,051)	21,474			20
21	Clerical & General Office Expenses	155,003	16,720	6,730	178,453		178,453		178,453			21
22	Employee Benefits & Payroll Taxes			660,129	660,129		660,129		660,129			22
23	Inservice Training & Education			4,248	4,248		4,248		4,248			23
24	Travel and Seminar			5,103	5,103		5,103	(104)	4,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			74,698	74,698		74,698		74,698			26
27	Other (specify):* Lost Items-Residents			62,321	62,321		62,321	(62,321)				27
28	TOTAL General Administration	232,186	16,720	1,383,503	1,632,409	(240,413)	1,391,996	(109,011)	1,282,985			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,423,641	736,798	1,863,550	5,023,989	(426,171)	4,597,818	(109,011)	4,488,807			29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation							82,699	82,699			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							(1,467)	(1,467)			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			459,900	459,900		459,900	(459,900)				34
35	Rent-Equipment & Vehicles			4,340	4,340		4,340		4,340			35
36	Other (specify):*											36
37	TOTAL Ownership			464,240	464,240		464,240	(378,668)	85,572			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			517,082	517,082	185,758	702,840		702,840			39
40	Barber and Beauty Shops			12,026	12,026		12,026		12,026			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					240,413	240,413		240,413			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			529,108	529,108	426,171	955,279		955,279			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,423,641	736,798	2,856,898	6,017,337		6,017,337	(487,679)	5,529,658			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 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	(1,467)			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	(104)			19
20	Contributions	(25)			20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(16,535)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(62,296)			24
25	Fund Raising, Advertising and Promotional	(30,051)			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	SUBTOTAL (A): (Sum of lines 1-29)	\$ (110,478)		\$	30

BHF USE ONLY							
48		49		50		51	
							52

B. If there are expenses experienced by the facility which do not appear in the
general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(377,201)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (377,201)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (487,679)		37

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

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

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

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		0	33	15
16			24	16
17		0	20	17
18				18
19			24	19
20		(25)	27	20
21				21
22		(16,535)	19	22
23				23
24		(62,296)	27	24
25		(30,051)	20	25
26				26
27		0	22	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	(108,907)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number St Claras Manor # 0050724 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	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	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	(16,535)	0	0	0	0	0	0	0	0	0	0	(16,535)	19
20	Fees, Subscriptions & Promotions	(30,051)	0	0	0	0	0	0	0	0	0	0	(30,051)	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	(104)	0	0	0	0	0	0	0	0	0	0	(104)	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):*	(62,321)	0	0	0	0	0	0	0	0	0	0	(62,321)	27
28	TOTAL General Administration	(109,011)	0	0	0	0	0	0	0	0	0	0	(109,011)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(109,011)	0	0	0	0	0	0	0	0	0	0	(109,011)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number St Claras Manor # 0050724 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	82,699	0	0	0	0	0	0	0	0	0	82,699	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,467)	0	0	0	0	0	0	0	0	0	0	(1,467)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(459,900)	0	0	0	0	0	0	0	0	0	(459,900)	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	(1,467)	(377,201)	0	0	0	0	0	0	0	0	0	(378,668)	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)	(110,478)	(377,201)	0	0	0	0	0	0	0	0	0	(487,679)	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
NFP-Board of Directors List Attached				St Clara's Senior Servi	Lincoln	Sponsor Org

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:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V			\$			\$	\$	1
2	V	34	Adjustment for Related Organization	459,900				(459,900)	2
3	V	30			St Clara's Senior Services Inc.	0.00%	82,699	82,699	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			\$ 459,900			\$ 82,699	\$ * (377,201)	14

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

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	None								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number St Claras Manor # 0050724 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	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	TOTALS					\$	\$		\$	25

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	Interest Income											(1,467)	10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$		\$			\$ (1,467)	14
15	TOTALS (line 9+line14)						\$		\$			\$ (1,467)	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.)

B. Real Estate Taxes

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.

FACILITY NAME	St Claras Manor	COUNTY	Logan
---------------	-----------------	--------	-------

CONTACT PERSON REGARDING THIS REPORT _____

A. Summary of Real Estate Tax Cost

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	

B. Real Estate Tax Cost Allocations

C. Tax Bills

Page 10A

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

53,286

B. General Construction Type:

Exterior

Brick

Frame

Wood

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).

St. Clara's Senior Services - Owns real and personal property.

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:

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

HFS 3745 (N-4-99)

IL478-2471

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	140				\$ 1,624,882	\$		\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	1976		1976		65,361					9
10	1978		1978		3,451					10
11	1980		1980		8,793					11
12	1981		1981		11,439					12
13	1982		1982		3,826					13
14	1983		1983		1,535					14
15	1984		1984		4,031					15
16	1985		1985		7,859					16
17	1986		1986		2,541					17
18	1987		1987		10,753					18
19	1988		1988		1,006					19
20	1989		1989		1,431					20
21	1991		1991		8,799					21
22	1992		1992		17,963					22
23	1993		1993		15,564					23
24	1994		1994		51,022					24
25	1995		1995		124,932					25
26	1996		1996		102,380					26
27	1997		1997		39,247					27
28	Fire Sprinkler		1998		22,151					28
29	Transfer Switch		1998		4,819					29
30	Water Line		1998		6,379					30
31	Soffits		1998		3,950					31
32	Generator		1998		3,164					32
33	Heating, A/C Improvements		1998		8,664					33
34										34
35	Depreciation					57,886		57,886		35
36										36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number St Claras Manor

0050724

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37 Windows	1998	\$ 3,422	\$		\$	\$	\$	37
38 Sidewalks	1998	2,963						38
39 Fixtures	1999	224						39
40 Faucets	1999	1,532						40
41 Water System Improvements	1999	7,920						41
42 Windows	1999	23,400						42
43 Fixtures	1999	2,812						43
44 Faucets	1999	1,404						44
45 Heating & Cooling Unit	2000	4,050						45
46 Water System	2000	37,203						46
47 Glass Doors	2000	1,145						47
48 Remodeling	2000	4,581						48
49 Plumbing	2000	4,128						49
50 Windows	2000	600						50
51 Plumbing	2000	1,702						51
52 4 Ton Condensing Unit	2000	4,453						52
53 Windows	2000	5,400						53
54 Exhaust Fan	2000	1,100						54
55 Heating & Cooling Units	2000	4,050						55
56 Doors	2000	4,081						56
57 Porch Ceiling	2000	4,050						57
58 Exhaust Fan	2000	2,046						58
59 Concrete Pad	2000	5,398						59
60 Fire Sprinkler	2001	1,304						60
61 Faucets	2001	3,432						61
62 Patio Roof	2001	1,532						62
63 Exhaust Fan	2001	1,000						63
64 A/C Unit	2001	16,312						64
65 A/C Kitchen	2001	6,850						65
66								66
67								67
68								68
69								69
70 TOTAL (lines 4 thru 69)		\$ 2,314,036	\$ 57,886		\$ 57,886	\$	\$	70

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

Facility Name & ID Number St Claras Manor

0050724

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12A, Carried Forward		\$ 2,314,036	\$ 57,886		\$ 57,886			1
2								2
3 Code Alert Alarm	2002	5,600						3
4 Ceiling Fan	2002	996						4
5 Heat Cool Units	2002	4,550						5
6 Carpet	2002	2,361						6
7 Seal Coat Parking Lot	2002	3,342						7
8 Walk-In Cooler	2002	17,518						8
9 Roof Replacement	2002	92,577						9
10 Door	2002	824						10
11 Wide Area Network Wiring	2002	3,167						11
12								12
13 Roof Replacement	2003	53,524						13
14 Facility Wiring	2003	11,041						14
15 Remodel Bathrooms	2003	33,616						15
16 Closet Doors	2003	4,188						16
17 Water Heaters and Storage Tank	2003	38,929						17
18 Capital Report Adj	2003	(10,796)						18
19 Furnace	2004	1,800						19
20 Remodel Activity room-- carpet	2004	2,624						20
21 Heat Cool Units	2004	8,094						21
22 Remodel Employee Lounge	2004	2,955						22
23 Electric Door opener	2004	1,598						23
24 Drain Grate	2004	2,350						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)		\$ 2,594,894	\$ 57,886		\$ 57,886			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	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		\$ 2,594,894	\$ 57,886		\$ 57,886			1
2								2
3 Code Alert System	2005	726						3
4 Kitchen Hood	2005	1,662						4
5 Wander System	2005	2,543						5
6 Hallway remodel -- Paint and carpet	2005	20,919						6
7 A/C Units	2005	1,187						7
8 Fire Suppression	2005	1,845						8
9								9
10 A/C Units	2006	1,843						10
11 Security Camera	2006	1,059						11
12 PTAC Units	2006	1,287						12
13 A/C Units	2006	1,207						13
14								14
15								15
16								16
17 Simplex Fire Alarm	2008	8,105						17
18								18
19 Otis elevator	2008	183,160						19
20 Fire Alarm	2008	18,587						20
21								21
22 Fire Sprinkler	2009	4,477						22
23								23
24 Masonry --building exterior	2010	11,260						24
25								25
26 Water heater & conditioner	2011	19,115						26
27 Roof	2011	88,421						27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 2,962,297	\$ 57,886		\$ 57,886			34

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

Facility Name & ID Number St Claras Manor

0050724

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12C, Carried Forward		\$ 2,962,297	\$ 57,886		\$ 57,886	\$	\$	1
2								2
3 Rooftop Heating & Cooling Unit	2013	21,000						3
4 Lighting Retrofit	2013	4,482						4
5 Water Temperature Control & Mixing Valve	2013	4,370						5
6 A/C Unit	2013	2,540						6
7 Sprinkler Installation-Exterior Canopies	2013	5,580						7
8								8
9 New Generator	2014	43,875						9
10 Installation of Electrical Outlets	2014	4,432						10
11 Replace Condensing Unit	2014	4,528						11
12 Upgrade Tankless Water Heater	2014	26,198						12
13								13
14 Hot water boiler for laundry room	2015	5,680						14
15 PTAC installation	2015	2,563						15
16 Replace HVAC pump	2015	3,393						16
17 Install new hot water tank	2015	3,883						17
18 New 5 ton condensing unit	2015	3,300						18
19 Improve parking lot - sealcoat & stripe	2015	7,500						19
20								20
21 Install new grease trap	2016	8,002						21
22 Replace steps	2016	4,228						22
23 Replace sewer pump	2016	2,691						23
24 Install new water heaters	2016	9,180						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)		\$ 3,129,722	\$ 57,886		\$ 57,886	\$	\$	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	\$ 1,238,681	\$ 20,138	\$ 20,138	\$		\$	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,238,681	\$ 20,138	\$ 20,138	\$		\$	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		2015 Grand Caravan	2015	\$ 32,723	\$ 4,675	\$ 4,675	\$		\$
77									
78									
79									
80	TOTALS			\$ 32,723	\$ 4,675	\$ 4,675	\$		\$

E. Summary of Care-Related Assets					1	2
		Reference			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)			\$	4,401,126
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	86,083
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	86,083
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	

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		\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92		\$
93		
94		
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:St. Clara's Senior Services
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:				\$459,900			3
4	Additions							4
5								5
6								6
7	TOTAL				\$459,900			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:\$4,340Description:Copiers and televisions
- (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	None		\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

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

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

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

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

3. CLINICAL PORTION:

IN-HOUSE PROGRAM☒

IN OTHER FACILITY☐

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies		205		205
3	Classroom Wages (a)		5,506		5,506
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 5,711	\$	\$ 5,711
10	SUM OF line 9, col. 1 and 2 (e)	\$ 5,711			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

12345678										
	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	\$		\$ 203,589	\$		\$ 203,589	1
2	Licensed Speech and Language Development Therapist		hrs			124,246			124,246	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			189,247	746		189,993	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				164,161		164,161	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					21,597			21,597	13
14	TOTAL			\$		\$ 538,679	\$ 164,907		\$ 703,586	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	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 70,341	\$	1
2	Cash-Patient Deposits	27,433		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,111,291		3
4	Supply Inventory (priced at)	16,952		4
5	Short-Term Investments			5
6	Prepaid Insurance	19,052		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	488,838		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,733,907	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)			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
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,733,907	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 197,698	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	27,433		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	174,240		30
31	Accrued Taxes Payable (excluding real estate taxes)	2,380		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	Bed Tax	27,406		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 429,157	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 429,157	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,304,750	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,733,907	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,857,452	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,857,452	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(552,702)	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)	\$ (552,702)	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)	\$ 1,304,750	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number St Claras Manor

0050724

Report Period Beginning: 01/01/16

Ending: 12/31/16

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	\$ 4,873,244	1
2	Discounts and Allowances for all Levels	(1,607,764)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,265,480	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,809,845	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,809,845	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	582	12
13	Barber and Beauty Care	13,935	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	268,900	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	(574)	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 282,843	23
	D. Non-Operating Revenue		
24	Contributions	105,000	24
25	Interest and Other Investment Income***	1,467	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 106,467	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,464,635	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,047,893	31
32	Health Care	2,343,687	32
33	General Administration	1,632,409	33
	B. Capital Expense		
34	Ownership	464,240	34
	C. Ancillary Expense		
35	Special Cost Centers	529,108	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,017,337	40
41	Income before Income Taxes (line 30 minus line 40)**	(552,702)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (552,702)	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.

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	1,832	1,928	\$ 64,583	\$ 33.50	1
2	Assistant Director of Nursing			0		2
3	Registered Nurses	9,798	10,314	313,253	30.37	3
4	Licensed Practical Nurses	15,951	16,790	416,413	24.80	4
5	CNAs & Orderlies	49,374	51,973	707,411	13.61	5
6	CNA Trainees	598	630	5,506	8.74	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,120	2,232	64,254	28.79	8
9	Activity Director					9
10	Activity Assistants	5,743	6,045	67,214	11.12	10
11	Social Service Workers	1,796	1,890	44,050	23.31	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	23,708	24,956	274,340	10.99	15
16	Dishwashers					16
17	Maintenance Workers	3,171	3,338	42,551	12.75	17
18	Housekeepers	9,240	9,726	127,364	13.10	18
19	Laundry	5,271	5,548	64,516	11.63	19
20	Administrator	1,984	2,088	77,183	36.97	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,991	7,359	155,003	21.06	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	137,577	144,817	\$ 2,423,641 *	\$ 16.74	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		\$ 0		35
36	Medical Director		24,976		36
37	Medical Records Consultant		2,291		37
38	Nurse Consultant				38
39	Pharmacist Consultant		5,170		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		3,772		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 36,209		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$ 3,633		50
51	Licensed Practical Nurses		36,797		51
52	Certified Nurse Assistants/Aides		199,397		52
53	TOTAL (lines 50 - 52)		\$ 239,827		53

Facility Name & ID Number		St Claras Manor		STATE OF ILLINOIS		Report Period Beginning:		01/01/16		Page 21	
				# 0050724		Ending:		12/31/16			
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	
Mike Eads				\$ 77,183	Workers' Compensation Insurance		\$ 75,869	IDPH License Fee		\$	
					Unemployment Compensation Insurance		13,551	Advertising: Employee Recruitment			5,541
					FICA Taxes		185,409	Health Care Worker Background Check			
					Employee Health Insurance		354,365	(Indicate # of checks performed)			3,546
					Employee Meals						
					Illinois Municipal Retirement Fund (IMRF)*						
					Other Benefits		30,935	PR			7,422
TOTAL (agree to Schedule V, line 17, col. 1)								Dues & Subscriptions			11,896
(List each licensed administrator separately.)				\$ 77,183				License & Fees			5,717
B. Administrative - Other											
Description				Amount				Less: Public Relations Expense			(7,422)
				\$				Non-allowable advertising			(5,226)
								Yellow page advertising		(	
TOTAL (agree to Schedule V, line 17, col. 3)				\$				TOTAL (agree to Sch. V, line 20, col. 8)		\$	21,474
(Attach a copy of any management service agreement)											
C. Professional Services								G. Schedule of Travel and Seminar**			
Vendor/Payee		Type		Amount	Description		Line #	Amount	Description		Amount
Heritage Operations Group		Mgmt		\$ 256,433				\$	Out-of-State Travel		\$
ADP		Payroll tax processing		1,183							
JM Abbott		Audit		9,329							
Principal Financial		401 k consulting		1,500					In-State Travel		
											4,044
											15
									Seminar Expense		1,044
											(104)
Legal adj to Zero				9,891					Entertainment Expense		(
TOTAL (agree to Schedule V, line 19, column 3)					TOTAL			\$	(agree to Sch. V, line 24, col. 8)		
(For legal fee disclosure, see page 39 of instructions)				\$ 278,336					TOTAL		\$ 4,999
						* Attach copy of IMRF notifications			**See instructions.		

Facility Name & ID Number <u>St Claras Manor</u>	STATE OF ILLINOIS # <u>0050724</u>	Report Period Beginning: <u>01/01/16</u>	Ending: <u>12/31/16</u>
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XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? No

(2) Are there any dues to nursing home associations included on the cost report? Yes
 If YES, give association name and amount. HCCI

(3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes

(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? No

(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? 7 Yrs

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 5,000 Line 10

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

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

(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. \$ 240,413
 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. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 4,059

(16) Travel and Transportation
 a. Are there costs included for out-of-state travel? No
 If YES, attach a complete explanation.
 b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
 c. What percent of all travel expense relates to transportation of nurses and patients? 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? Yes
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. \$ 0

(17) Has an audit been performed by an independent certified public accounting firm? Yes
 Firm Name: JM Abbott

(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. None Claimed
 Attach invoices and a summary of services for all architect and appraisal fees

St. Clara's Manor Inc.
HFS ID# 376075710001
HFS Cost Report - December 31, 2016
Board of Directors

<u>Member</u>	<u>Home City</u>	<u>State</u>
Clyde Reynolds - President	Lincoln	IL
Dr. Dennis Carroll	Lincoln	IL
Tonita Reifsteck	Lincoln	IL

St. Clara's Manor Inc.
HFS ID# 376075710001
HFS Cost Report - December 31, 2016
Schedule V - Column 5 Reclassifications

		<u>Add (Subtract)</u>
<u>Reclassification of Provider Participation Fees</u>		
Provider Participation Fee - \$1.50	Line 20, Col 3	(76,860)
Provider Assesment Fee - \$6.07	Line 20, Col 3	<u>(163,553)</u>
		<u>(240,413)</u>
Provider Participation Fee	Line 42	<u>240,413</u>
<u>Reclassification of Ancillary Services Cost</u>		
Cost of Drugs Purchased	Line 10(a), Col 2	(164,161)
Cost of Lab & Radiology Services Purchased	Line 10(a), Col 3	<u>(21,597)</u>
		<u>(185,758)</u>
Ancillary Service Centers	Line 39	<u>185,758</u>