

		FOR BHF USE					

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2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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

I. IDPH License ID Number: <u>0036723</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																
Facility Name: <u>St Vincents Home</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/20</u> to <u>12/31/20</u> 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.																																
Address: <u>1440 North 10th St</u> <u>Quincy</u> <u>62301</u> Number City Zip Code																																		
County: <u>Adams</u>																																		
Telephone Number: <u>217-224-3780</u> Fax # <u>217-224-3057</u>																																		
HFS ID Number: _____																																		
Date of Initial License for Current Owners: <u>10/01/1990</u>		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) <u>Danielle Boeding</u></td></tr><tr><td>(Title) <u>Administrator</u></td></tr><tr><td>(Signed) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Date) _____</td></tr><tr><td>(Print Name and Title) <u>David Reis</u> <u>President</u></td></tr><tr><td>(Firm Name & Address) <u>WDM Support Services</u> <u>1900 Harrison Street Quincy, IL 62301</u></td></tr><tr><td>(Telephone) <u>217-118-1950</u> Fax # <u>217-222-6053</u></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>Danielle Boeding</u>	(Title) <u>Administrator</u>	(Signed) _____	Paid Preparer	(Date) _____	(Print Name and Title) <u>David Reis</u> <u>President</u>	(Firm Name & Address) <u>WDM Support Services</u> <u>1900 Harrison Street Quincy, IL 62301</u>	(Telephone) <u>217-118-1950</u> Fax # <u>217-222-6053</u>																					
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<table><tr><td>☐</td><td>VOLUNTARY, NON-PROFIT</td></tr><tr><td>☐</td><td>Charitable Corp.</td></tr><tr><td>☐</td><td>Trust</td></tr><tr><td colspan="2">IRS Exemption Code _____</td></tr></table>	☐	VOLUNTARY, NON-PROFIT	☐	Charitable Corp.	☐	Trust	IRS Exemption Code _____		<table><tr><td>☒</td><td>PROPRIETARY</td></tr><tr><td>☐</td><td>Individual</td></tr><tr><td>☐</td><td>Partnership</td></tr><tr><td>☒</td><td>Corporation</td></tr><tr><td>☐</td><td>"Sub-S" Corp.</td></tr><tr><td>☐</td><td>Limited Liability Co.</td></tr><tr><td>☐</td><td>Trust</td></tr><tr><td>☐</td><td>Other _____</td></tr></table>	☒	PROPRIETARY	☐	Individual	☐	Partnership	☒	Corporation	☐	"Sub-S" Corp.	☐	Limited Liability Co.	☐	Trust	☐	Other _____	<table><tr><td>☐</td><td>GOVERNMENTAL</td></tr><tr><td>☐</td><td>State</td></tr><tr><td>☐</td><td>County</td></tr><tr><td>☐</td><td>Other _____</td></tr></table>	☐	GOVERNMENTAL	☐	State	☐	County	☐	Other _____
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In the event there are further questions about this report, please contact:		MAIL TO: BUREAU OF HEALTH FINANCE																																
Name: <u>Dave Reis</u>		ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES																																
Telephone Number: <u>217-228-1950</u>		201 S. Grand Avenue East																																
Email Address: _____		Springfield, IL 62763-0001																																
		Phone # (217) 782-1630																																

Facility Name & ID Number St Vincents Home

0036723 Report Period Beginning: 01/01/20 Ending: 12/31/20

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>90</u>	Skilled (SNF)	<u>90</u>	<u>32,940</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>90</u>	TOTALS	<u>90</u>	<u>32,940</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	<u>12,745</u>	<u>5,815</u>	<u>5,140</u>	<u>23,700</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>12,745</u>	<u>5,815</u>	<u>5,140</u>	<u>23,700</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 71.95%

D. How many bed reserve days during this year were paid by the Department? None (Do not include bed reserve days in Section B.)

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

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

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

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

I. On what date did you start providing long term care at this location? Date started 10/01/1990

J. Was the facility purchased or leased after January 1, 1978? YES ☒ Date 10/01/1990 NO ☐

K. Was the facility certified for Medicare during the reporting year? YES ☒ NO ☐ If YES, enter number of beds certified 90 and days of care provided 5,140

Medicare Intermediary CGS

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 2020 Fiscal Year: _____
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number St Vincents Home # 0036723 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	245,121	22,271	7,466	274,858		274,858		274,858			1
2	Food Purchase		198,296		198,296		198,296	(1,749)	196,547			2
3	Housekeeping	108,064	24,125		132,189		132,189		132,189			3
4	Laundry	47,872	10,759		58,631		58,631		58,631			4
5	Heat and Other Utilities			100,207	100,207		100,207		100,207			5
6	Maintenance	87,522	19,083	57,642	164,247		164,247		164,247			6
7	Other (specify):*											7
8	TOTAL General Services	488,579	274,534	165,315	928,428		928,428	(1,749)	926,679			8
	B. Health Care and Programs											
9	Medical Director			10,800	10,800		10,800		10,800			9
10	Nursing and Medical Records	1,945,395	199,421	70,987	2,215,803		2,215,803	(3,328)	2,212,475			10
10a	Therapy			700,301	700,301		700,301		700,301			10a
11	Activities	73,010	2,966	9,259	85,235		85,235		85,235			11
12	Social Services	49,507		15,480	64,987		64,987		64,987			12
13	CNA Training											13
14	Program Transportation		3,030		3,030		3,030	(25)	3,005			14
15	Other (specify):* penalty			10,000	10,000		10,000	(10,000)				15
16	TOTAL Health Care and Programs	2,067,912	205,417	816,827	3,090,156		3,090,156	(13,353)	3,076,803			16
	C. General Administration											
17	Administrative	91,347			91,347		91,347	(6,000)	85,347			17
18	Directors Fees											18
19	Professional Services			168,173	168,173		168,173	(73,169)	95,004			19
20	Dues, Fees, Subscriptions & Promotions			57,743	57,743		57,743	(38,548)	19,195			20
21	Clerical & General Office Expenses	256,316	21,034	38,079	315,429		315,429	314	315,743			21
22	Employee Benefits & Payroll Taxes			410,488	410,488		410,488		410,488			22
23	Inservice Training & Education			1,338	1,338		1,338		1,338			23
24	Travel and Seminar							193	193			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			71,791	71,791		71,791		71,791			26
27	Other (specify):* sales tax			255	255		255	(255)				27
28	TOTAL General Administration	347,663	21,034	747,867	1,116,564		1,116,564	(117,465)	999,099			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,904,154	500,985	1,730,009	5,135,148		5,135,148	(132,567)	5,002,581			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			178,234	178,234		178,234	(564)	177,670			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			130,475	130,475		130,475	(2,289)	128,186			32
33	Real Estate Taxes			46,823	46,823		46,823		46,823			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* income tax			8,042	8,042		8,042	(8,042)				36
37	TOTAL Ownership			363,574	363,574		363,574	(10,895)	352,679			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		189,645	37,198	226,843		226,843		226,843			39
40	Barber and Beauty Shops		31	1,670	1,701		1,701		1,701			40
41	Coffee and Gift Shops			(686)	(686)		(686)		(686)			41
42	Provider Participation Fee			163,599	163,599		163,599		163,599			42
43	Other (specify):* Bad Debts			108,713	108,713		108,713	(108,713)				43
44	TOTAL Special Cost Centers		189,676	310,494	500,170		500,170	(108,713)	391,457			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	2,904,154	690,661	2,404,077	5,998,892		5,998,892	(252,175)	5,746,717			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	(1,522)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients	(3,328)	10		7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(564)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	(227)	2		11
12	Non-Working Officer's or Owner's Salary	(72,000)	19		12
13	Sales Tax	(255)	27		13
14	Non-Care Related Interest	(2,289)	32		14
15	Non-Care Related Owner's Transactions	(6,000)	17		15
16	Personal Expenses (Including Transportation)	(25)	14		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(10,000)	15		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(480)	20		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(108,713)	43		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax	(8,042)	36		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(38,590)	20		28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (252,035)		\$	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)	(140)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (140)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (252,175)		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.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

St Vincents Home

ID# 0036723

Report Period Beginning: 01/01/20

Ending: 12/31/20

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
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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 St Vincents Home # 0036723 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	(1,749)	0	0	0	0	0	0	0	0	0	0	(1,749)	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	(1,749)	0	0	0	0	0	0	0	0	0	0	(1,749)	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	(3,328)	0	0	0	0	0	0	0	0	0	0	(3,328)	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	(25)	0	0	0	0	0	0	0	0	0	0	(25)	14
15	Other (specify):*	(10,000)	0	0	0	0	0	0	0	0	0	0	(10,000)	15
16	TOTAL Health Care and Programs	(13,353)	0	0	0	0	0	0	0	0	0	0	(13,353)	16
	C. General Administration													
17	Administrative	(6,000)	0	0	0	0	0	0	0	0	0	0	(6,000)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(72,000)	(1,169)	0	0	0	0	0	0	0	0	0	(73,169)	19
20	Fees, Subscriptions & Promotions	(39,070)	522	0	0	0	0	0	0	0	0	0	(38,548)	20
21	Clerical & General Office Expenses	0	314	0	0	0	0	0	0	0	0	0	314	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	193	0	0	0	0	0	0	0	0	0	193	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):*	(255)	0	0	0	0	0	0	0	0	0	0	(255)	27
28	TOTAL General Administration	(117,325)	(140)	0	0	0	0	0	0	0	0	0	(117,465)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(132,427)	(140)	0	0	0	0	0	0	0	0	0	(132,567)	29

Summary B

12/31/20

[illegible]

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
<u>Carlyle Healthcare Center Inc.</u>	<u>100</u>	<u>Carlyle Healthcare</u>	<u>Carlyle</u>	<u>WDM health Services</u>	<u>Quincy</u>	<u>MGMT</u>
		<u>Clinton Manor</u>	<u>New Baden</u>			

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	19	<u>Managemnet</u>	\$ <u>36,000</u>	<u>WDM Health Services Inc.</u>	<u>0.00%</u>	\$ <u>28,839</u>	\$ <u>(7,161)</u>	1
2	V	19	<u>Accounting</u>				<u>1,423</u>	<u>1,423</u>	2
3	V	19	<u>Legal</u>				<u>4,028</u>	<u>4,028</u>	3
4	V	20	<u>Subscriptions</u>				<u>522</u>	<u>522</u>	4
5	V	19	<u>professional fees</u>				<u>541</u>	<u>541</u>	5
6	V	21	<u>Office</u>				<u>314</u>	<u>314</u>	6
7	V	24	<u>Travel</u>				<u>193</u>	<u>193</u>	7
8	V	21	<u>Postage</u>						8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ <u>36,000</u>			\$ <u>35,860</u>	\$ * <u>(140)</u>	14

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

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 St Vincents Home # 0036723 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	Ann Reis	Secretary	St. Vincents			10	20.00		\$		1
2	Sue Gray	Treasurer	St. Vincents			10	20.00				2
3	David Reis	President	St. Vincents			10	20.00				3
4	Carlyle Healthcare owns 100 % of the St. Vincents Stock			100.00							4
5	Ann Reis	Secretary	Carlyle Healthcare	45.00		10	20.00				5
6	Sue Gray	Treasurer	Carlyle Healthcare	50.00		10	20.00				6
7	David Reis	President	Carlyle Healthcare			10	20.00				7
8	Ann Reis		Clinton Manor			2	4.00				8
9	WDM Health Services	Managemnet Fees						MGMT Fees	36,000	19-3	9
10	Chris Reis	VP Operations	St.Vincents/Carlyle	5.00	119,024				66,437	22-1	10
11	Janeane Reis	HR Director	St.Vincents/Carlyle		71,241				59,849	22-1	11
12											12
13								TOTAL	\$ 162,286		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 Vincents Home # 0036723 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 WDM Health Services Inc
Street Address 1900 Harrison Street
City / State / Zip Code Quincy, Illinois
Phone Number (217228-1950
Fax Number (2172226053

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	19	Management	Patient Days	49,966	2	\$ 60,800	\$ 60,800	23,700	\$ 28,839	1
2	19	Accounting	Patient Days	49,966	2	3,000		23,700	1,423	2
3	19	Legal	Patient Days	49,966	2	8,492		23,700	4,028	3
4	20	Subscriptions	Patient Days	49,966	2	1,100		23,700	522	4
5	19	Professional Fees	Patient Days	49,966	2	1,140		23,700	541	5
6	21	Office	Patient Days	49,966	2	663		23,700	314	6
7	24	Travel exp	Patient Days	49,966	2	406		23,700	193	7
8	21	postsage	Patient Days	49,966	2	24		23,700	11	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					\$ 75,625	\$ 60,800		\$ 35,871	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	First Bankers		X	Mortgage	\$21,014.00	02/28/20	\$ 3,220,000	\$ 2,520,289	01/28/35	4.2500	\$ 96,164	1	
2											**	2	
3												3	
4												4	
5												5	
	Working Capital												
6	First Bankers		X	Line of credit		09/27/20	746,000	220,411	09/27/21	4.2500	22,470	6	
7	Carlyle Healthcare	X		Generator loan	\$1,475.00	11/01/19	78,600	33,648	11/02/22	4.7500	2,047	7	
8												8	
9	TOTAL Facility Related				\$22,489.00		\$ 4,044,600	\$ 2,774,348			\$ 120,681	9	
	B. Non-Facility Related*												
10	Interest		X	Finance charges							9,794	10	
11	Interest Income										(2,289)	11	
12												12	
13	** Nursing home portion only											13	
14	TOTAL Non-Facility Related						\$	\$			\$ 7,505	14	
15	TOTALS (line 9+line14)						\$ 4,044,600	\$ 2,774,348			\$ 128,186	15	

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

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2019 report.			\$	46,139	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.)			\$	2019 46823	2
3. Under or (over) accrual (line 2 minus line 1).			\$	684	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	46,823	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.			\$	46,823	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2015	57,822	8	
		2016	46,531	9	
		2017	45,297	10	
		2018	45,452	11	
		2019	46,823	12	
				FOR BHF USE ONLY	
		13	FROM R. E. TAX STATEMENT FOR 2019 \$		13
		14	PLUS APPEAL COST FROM LINE 5 \$		14
		15	LESS REFUND FROM LINE 6 \$		15
		16	AMOUNT TO USE FOR RATE CALCULATION \$		16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME St Vincents Home COUNTY Adams

FACILITY IDPH LICENSE NUMBER 0036723

CONTACT PERSON REGARDING THIS REPORT Danielle Boeding

TELEPHONE 217-2243780 FAX #: 217-224-3827

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2019 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2019.

(A)	(B)	(C)	(D)
			<u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to</u>
			<u>Nursing Home</u>
1. 23-7-0068-000-00	Nursing Home	\$ 46,823.36	\$ 46,823.36
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 46,823.36	\$ 46,823.36

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 X NO

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

C. Tax Bills

Attach copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

PLEASE NOTE: Payment information from the Internet or otherwise is not considered acceptable tax bill documentation . Facilities located in Cook County are required to provide copies of their original second installment tax bill.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

38,109

B. General Construction Type:

Exterior

Brick

Frame

cinder block/steel

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).

Assiste Living units 10,000 sq Ft

Casper casper village 26 Independent cottages 39,000 sq ft

CILA 4 bedrooms 3200 sq feet

Community Center 3000 sq feet

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.					
	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Nursing Home	114,177	1990	\$ 61,500	1
2					2
3	TOTALS	114,177		\$ 61,500	3

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	67		1990	1976	\$ 963,000	\$ 24,769	30	\$ 24,769		\$ 963,000
5	13		1999	1998	878,056	31,646	30	31,646		627,529
6										
7										
8										
	Improvement Type**									
9	LAUNDRY ROOM			1999	68,109					68,109
10	GLASS ENCLOSER			1990	2,972					2,972
11	DINNING ROOM ADDITION			1991	86,996					86,996
12	GARAGE			1991	35,000					35,000
13	LAND IMPROVEMENTS			1991	13,130					13,130
14	CONCRETE DRVWY LOT 1			1993	10,580					10,580
15	FIREWALL			1993	1,808					1,808
16	CONCRETE DRVWY LOT 2			1997	83,961					83,961
17	NEW ROOF			1997	82,806					82,806
18	LANDSCAPING			1997	10,358					10,358
19	ROOFTOP A/C UNITS			1997	6,995					6,995
20	HANDRAILS			1998	11,165					11,165
21										
22	REMODELING HALLWAYS			1998	26,569					26,569
23	FIRE DAMPERS			1999	7,122					7,122
24	8 PATIENT ROOM REMODELING			1999	11,018					11,018
25	LEVEL BUILDING			2000	74,150	936	20	936		74,150
26	DOORS CLOSERS,NEW VENTILATION, ELECTRICAL			2000	15,450					15,450
27	RAILING			2000	2,997					2,997
28	WATER HEATER			2000	4,851					4,851
29	LAND IMPROVEMENTS			2001	4,522					4,522
30	NEW KITCHEN			2001	55,641	214	15	214		55,515
31										
32	SMOKE DETECTORS			2002	2,562					2,502
33										
34	NEW HOT/COLD WATER LINES 100/200 WINGS			2005	29,851	995	30	995		15,091
35	LANDSCAPING/PARKING LOT LIGHTS			2006	55,446	2,789	20	2,789		38,945
36	ROOF HTG/AC			2008	3,976	265	15	265		3,402

*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 Vincents Home

0036723

Report Period Beginning:

01/01/20

Ending:

12/31/20

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	Emergency Wiring	2009	\$ 6,400	\$ 320	20	\$ 320		\$ 3,634	37
38	Dietary A/C	2010	6,570		8			6,570	38
39	500 Wing Zone Control	2010	15,512	1,034	15	1,034		14,492	39
40	5 Ton A/C	2010	7,319	488	15	488		5,205	40
41									41
42	New Nurse Station for 300/500 wing	2011	11,871	791	15	791		7,385	42
43	Roof Top A/C	2012	5,282	100	8	100		5,282	43
44	Sprinkler Replacement for 100/200 wing	2012	32,010	2,134	15	2,134		17,427	44
45	Outside Freezor/Refrigertor	2012	21,770	1,451	15	1,451		11,972	45
46	400 Wing Dementia unit drywall/steel studs	2012	10,206	865	15	684	(181)	5,870	46
47	400Wing Dementia doors/windows	2012	11,565	771	15	771		6,360	47
48	400 Wing Dementia electrical	2012	12,505	834	15	834		6,878	48
49	400 Wing Dementia Paint	2012	572	38	15	38		314	49
50	400 Wing Dementia patio/steel fence/concrete	2012	10,045	670	15	670		5,525	50
51	400Wing Dementia plumbing	2012	3,594	240	15	240		1,978	51
52	400 Wing Dementia ceiling/insulation	2012	6,701	447	15	447		3,586	52
53	400 Wing Dementia sprinkler/smoke/fire alarms	2012	3,652	243	15	243		2,007	53
54	400 Wing Dementia wonder guard security	2012	11,708	781	15	781		3,440	54
55	300 Wing Plumbing	2013	24,049	1,603	15	1,603		11,356	55
56	300 Wing Materilas /Labor	2013	42,981	3,190	15	2,807	(383)	20,681	56
57	300 Wing Flooring	2013	12,441	829	15	829		5,873	57
58	5 new roof top units	2014	38,695	2,580	15	2,580		16,124	58
59	LED ceiling lights	2015	16,364	818	20	818		4,772	59
60	Shingle Roof 100/200 wing	2015	43,000	2,150	20	2,150		12,537	60
61	Flat Roof 300/400/500 wings	2015	74,500	3,725	20	3,725		20,798	61
62	dinning room a/c	2016	11,445	1,434	8	1,434		6,423	62
63	dinning rm windows	2016	3,793	474	8	474		2,094	63
64	dinning rm doors/ceiling	2016	9,021	1,128	8	1,128		4,605	64
65	generator	2017	84,073	5,604	15	5,604		17,280	65
66	generator wiring/concrete/labor/materials	2017	48,335	3,222	15	3,222		9,934	66
67	redo elevator	2020	11,645	259	15	259		259	67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,146,715	\$ 99,837		\$ 99,273	\$ (564)	\$ 2,507,204	70

**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	\$ 546,143	\$ 70,466	\$ 70,466	\$	8	\$ 364,426	71
72	Current Year Purchases	39,788	2,792	2,792		8	2,792	72
73	Fully Depreciated Assets	266,559					266,599	73
74								74
75	TOTALS	\$ 852,490	\$ 73,258	\$ 73,258	\$		\$ 633,817	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	2000 GMC	2009	\$ 12,000	\$	\$	\$		\$ 12,000
77	Facility	2013 Dodge Handcaped Van	2013	44,135					44,135
78	Facility	2015 chev Equinox	2016	25,696	5,139	5,139		5	25,696
79									
80	TOTALS			\$ 81,831	\$ 5,139	\$ 5,139	\$		\$ 81,831

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)			\$	4,142,536
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	178,234
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	177,670
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	(564)
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	3,222,852

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:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?YESNO
- If NO, see instructions.

		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:YESNO

Terms:

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

15. Is Movable equipment rental included in building rental?YESNO
16. Rental Amount for movable equipment: \$

Description:
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning

Ending

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

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

* 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				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

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

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

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

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A-3	hrs	\$		\$ 294,175	\$		\$ 294,175	1
2	Licensed Speech and Language Development Therapist	10A-3	hrs			135,415			135,415	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A-3	hrs			270,711			270,711	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				189,645		189,645	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Lab	39-3					37,198		37,198	12
13	Other (specify):									13
14	TOTAL			\$		\$ 700,301	\$ 226,843		\$ 927,144	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.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 316,045	\$ 954,334	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,336,973	1,336,973	3
4	Supply Inventory (priced at)	32,339	32,339	4
5	Short-Term Investments			5
6	Prepaid Insurance	29,811	29,811	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,715,168	\$ 2,353,457	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	61,500	217,282	13
14	Buildings, at Historical Cost	3,011,783	5,254,451	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,136,192	1,653,351	16
17	Accumulated Depreciation (book methods)	(3,223,402)	(4,818,042)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Goodwill</u>		46,126	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 986,073	\$ 2,353,168	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,701,241	\$ 4,706,625	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 173,046	\$ 173,046	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	142,805	142,805	29
30	Accrued Salaries Payable	200,235	200,235	30
31	Accrued Taxes Payable (excluding real estate taxes)	8,701	8,701	31
32	Accrued Real Estate Taxes(Sch.IX-B)	46,823	91,116	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 571,610	\$ 615,903	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	2,016,230	2,520,289	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>line of credit</u>	220,411	220,411	43
44	<u>deferred income</u>		209,920	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,236,641	\$ 2,950,620	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,808,251	\$ 3,566,523	46
47	TOTAL EQUITY(page 18, line 24)	\$ (107,010)	\$ 1,143,102	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,701,241	\$ 4,709,625	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 469,996	1
2	Restatements (describe):		2
3	<u>paid in surplus</u>	637,155	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,107,151	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(158,138)	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) <u>Other divisions</u>	194,089	16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 35,951	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)	\$ 1,143,102	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number St Vincents Home

0036723

Report Period Beginning:

01/01/20

Ending:

12/31/20

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	\$ 6,187,910	1
2	Discounts and Allowances for all Levels	(619,922)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,567,988	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	255,732	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 255,732	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	821	12
13	Barber and Beauty Care	2,376	13
14	Non-Patient Meals	1,522	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	2,699	17
18	Sale of Supplies to Non-Patients	229	18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 7,647	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,289	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,289	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	see attachesd list	7,098	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 7,098	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,840,754	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	928,428	31
32	Health Care	3,090,156	32
33	General Administration	1,116,564	33
	B. Capital Expense		
34	Ownership	363,574	34
	C. Ancillary Expense		
35	Special Cost Centers	336,571	35
36	Provider Participation Fee	163,599	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,998,892	40
41	Income before Income Taxes (line 30 minus line 40)**	(158,138)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (158,138)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 959,890	44
45	Private Pay - Net Inpatient Revenue	1,025,095	45
46	Medicare - Net Inpatient Revenue	2,793,487	46
47	Other-(specify) covid-19	789,516	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,567,988	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	1,731	2,006	\$ 65,699	\$ 32.75	1
2	Assistant Director of Nursing					2
3	Registered Nurses	15,261	16,601	458,692	27.63	3
4	Licensed Practical Nurses	19,695	21,560	507,917	23.56	4
5	CNAs & Orderlies	56,556	60,004	850,043	14.17	5
6	CNA Trainees	4,692	4,807	63,044	13.12	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,915	2,123	30,821	14.52	9
10	Activity Assistants	3,423	3,857	42,189	10.94	10
11	Social Service Workers	2,509	2,813	49,507	17.60	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,960	2,088	48,878	23.41	14
15	Cook Helpers/Assistants	11,351	11,983	148,191	12.37	15
16	Dishwashers	4,286	4,447	48,051	10.81	16
17	Maintenance Workers	4,424	4,573	87,522	19.14	17
18	Housekeepers	8,725	9,259	108,064	11.67	18
19	Laundry	3,703	4,138	47,872	11.57	19
20	Administrator	1,856	2,088	91,348	43.75	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,439	11,006	256,316	23.29	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)	152,526	163,353	\$ 2,904,154 *	\$ 17.78	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	127	\$ 6,960	1-3	35
36	Medical Director		10,800	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	440	9,805	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	19	1,759	11-3	44
45	Social Service Consultant	19	15,480	12-3	45
46	Other(specify) Religious		7,500	11-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	605	\$ 52,304		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	48	\$ 16,018	10-3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	48	\$ 16,018		53

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

** See instructions.

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		
Danielle Boeding	Administrator		\$ 91,347	Workers' Compensation Insurance		\$ 58,314	IDPH License Fee		\$ 3,980		
				Unemployment Compensation Insurance		14,212	Advertising: Employee Recruitment		987		
				FICA Taxes		164,008	Health Care Worker Background Check		1,280		
				Employee Health Insurance		168,974	(Indicate # of checks performed 33)				
				Employee Meals			Patient Background Checks 146		1,565		
				Illinois Municipal Retirement Fund (IMRF)*			Advertising		38,590		
				Employee physicals		2,730	Subscriptions		2,912		
				401k Plan exp		2,250	Ill sec of state		1,229		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)							PAC dues		(480)		
							IHCA		7,200		
B. Administrative - Other							Less: Public Relations Expense		()		
							Non-allowable advertising		(38,590)		
							Yellow page advertising		()		
							TOTAL (agree to Sch. V, line 20, col. 8)		\$ 18,673		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)							G. Schedule of Travel and Seminar**				
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees							
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description			Amount	
			\$			\$	Out-of-State Travel			\$	
Herman Bodewes	Legal		13,033								
SB2	Legal		40,000								
Reis Security	security monitoring		2,400				In-State Travel				
WDM Health Services Inc	Managemnet		36,000								
Wdm Support Services	Accounting/payroll/cost		72,000								
Time Track	Time and attendance		4,740								
							Seminar Expense				
non allow			(72,000)								
see pga 6			(1,169)								
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)				TOTAL			\$	Entertainment Expense			()
								(agree to Sch. V, line 24, col. 8)			
								TOTAL			\$

*** Attach copy of IMRF notifications**

****See instructions.**

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?
If YES, give association name and amount.

Yes
IHCA 7200

(3)

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

Yes
480

(4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?
If YES, what is the capacity?

No

(5)

Have you properly capitalized all major repairs and equipment purchases?
What was the average life used for new equipment added during this period?

Yes
8yrs

(6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$ 45,608 Line 10-2

(7)

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

Yes

(8)

Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease.

N

(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.
This amount is to be recorded on line 42 of Schedule V.

\$ 163,599

(12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?
If YES, attach an explanation of the allocation.

Yes
- (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?
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.

No

(15)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.
Has any meal income been offset against related costs?

\$ 1,522
Yes Indicate the amount. \$ 400

(16)

Travel and Transportation

a.

Are there costs included for out-of-state travel?
If YES, attach a complete explanation.

No

b.

Do you have a separate contract with the Department to provide medical transportation for residents?
If YES, please indicate the amount of income earned from such a program during this reporting period.

No

c.

What percent of all travel expense relates to transportation of nurses and patients?

100

d.

Have vehicle usage logs been maintained?

No

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?
Indicate the amount of income earned from providing such transportation during this reporting period.

N
\$

(17)

Has an audit been performed by an independent certified public accounting firm?
Firm Name:

N

(18)

Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V?

Yes

(19)

Has a schedule for the legal fees reported on the cost report been provided by the facility?
See page 39 of the instructions for details.
Attach invoices and a summary of services for all architect and appraisal fees.

Yes