

		FOR BHF USE					

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2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

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.

<p>I. IDPH License ID Number: <u>0027045</u></p> <p>Facility Name: <u>St Josephs Home F-T Elderly</u></p> <p>Address: <u>80 W Northwest Hwy</u> <u>Palatine</u> <u>60067</u> Number City Zip Code</p> <p>County: <u>Cook</u></p> <p>Telephone Number: <u>(847) 358-5700</u> Fax # <u>(847) 358-5719</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>01/09/1967</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input checked="" type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code <u>501c3</u></td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Mother Marguerite McCarthy</u> Telephone Number: <u>(847) 358-5700</u> Email Address: _____</p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code <u>501c3</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2015</u> to <u>12/31/2015</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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2" style="width: 20%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> </tr> <tr> <td>(Type or Print Name) <u>Mother Marguerite McCarthy</u> (Date) _____</td> </tr> <tr> <td></td> <td>(Title) <u>President</u></td> </tr> <tr> <td rowspan="5">Paid Preparer</td> <td>(Signed) _____</td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>Elizabeth Vaccariello</u> <u>Vice President</u></td> </tr> <tr> <td>(Firm Name & Address) <u>Varey & Vaccariello CPAs PC</u> <u>2205 Point Boulevard, Suite 210, Elgin, IL 60123</u></td> </tr> <tr> <td>(Telephone) <u>(847) 228-6977</u> Fax # <u>(847) 228-0317</u></td> </tr> </table> <p>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</p>	Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>Mother Marguerite McCarthy</u> (Date) _____		(Title) <u>President</u>	Paid Preparer	(Signed) _____	(Date) _____	(Print Name and Title) <u>Elizabeth Vaccariello</u> <u>Vice President</u>	(Firm Name & Address) <u>Varey & Vaccariello CPAs PC</u> <u>2205 Point Boulevard, Suite 210, Elgin, IL 60123</u>	(Telephone) <u>(847) 228-6977</u> Fax # <u>(847) 228-0317</u>
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Facility Name & ID Number St Josephs Home F-T Elderly

0027045 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

III. STATISTICAL DATA

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

N/A

	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>20</u>	Skilled (SNF)	<u>20</u>	<u>7,300</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>39</u>	Intermediate (ICF)	<u>39</u>	<u>14,235</u>	3
4		Intermediate/DD			4
5	<u>5</u>	Sheltered Care (SC)	<u>5</u>	<u>1,825</u>	5
6		ICF/DD 16 or Less			6
7	<u>64</u>	TOTALS	<u>64</u>	<u>23,360</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment			
		Medicaid Recipient	Private Pay	Other	
8	SNF				8
9	SNF/PED				9
10	ICF	<u>15,886</u>	<u>2,045</u>	<u>2,295</u>	<u>20,226</u>
11	ICF/DD				11
12	SC		<u>699</u>		<u>699</u>
13	DD 16 OR LESS				13
14	TOTALS	<u>15,886</u>	<u>2,744</u>	<u>2,295</u>	<u>20,925</u>

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.58%

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 01/09/1967

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

YES Date _____ NO

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

YES NO If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2015 Fiscal Year: 12/31/2015

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

Facility Name & ID Number

St Josephs Home F-T Elderly

0027045

Report Period Beginning:

01/01/2015

Ending:

12/31/2015

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	459,981	14,038	152,908	626,927		626,927	(104,528)	522,399		1
2	Food Purchase		147,294		147,294		147,294		147,294		2
3	Housekeeping		18,216	252,360	270,576		270,576		270,576		3
4	Laundry	84,657	17,028	25,129	126,814		126,814	(10,007)	116,807		4
5	Heat and Other Utilities			228,958	228,958		228,958	(123,680)	105,278		5
6	Maintenance	196,710	48,708	175,553	420,971	1	420,972	(6,287)	414,685		6
7	Other (specify):*	68,032		20,989	89,021		89,021		89,021		7
8	TOTAL General Services	809,380	245,284	855,897	1,910,561	1	1,910,562	(244,502)	1,666,060		8
	B. Health Care and Programs										
9	Medical Director			2,400	2,400		2,400		2,400		9
10	Nursing and Medical Records	2,040,391	90,305	205,074	2,335,770		2,335,770		2,335,770		10
10a	Therapy	70,280			70,280		70,280		70,280		10a
11	Activities	96,018	23,366	18,490	137,874		137,874		137,874		11
12	Social Services	47,075		852	47,927		47,927		47,927		12
13	CNA Training										13
14	Program Transportation			6,247	6,247		6,247		6,247		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,253,764	113,671	233,063	2,600,498		2,600,498		2,600,498		16
	C. General Administration										
17	Administrative			89,616	89,616		89,616		89,616		17
18	Directors Fees										18
19	Professional Services			71,742	71,742		71,742		71,742		19
20	Dues, Fees, Subscriptions & Promotions			90,568	90,568		90,568	(72,166)	18,402		20
21	Clerical & General Office Expenses	342,418	40,600	115,597	498,615		498,615		498,615		21
22	Employee Benefits & Payroll Taxes			794,036	794,036		794,036		794,036		22
23	Inservice Training & Education			5,889	5,889		5,889		5,889		23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation			18,742	18,742		18,742		18,742		25
26	Insurance-Prop.Liab.Malpractice			46,323	46,323		46,323	(7,453)	38,870		26
27	Other (specify):*										27
28	TOTAL General Administration	342,418	40,600	1,232,513	1,615,531		1,615,531	(79,619)	1,535,912		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,405,562	399,555	2,321,473	6,126,590	1	6,126,591	(324,121)	5,802,470		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 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			576,931	576,931	(1)	576,930	(80,572)	496,358			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			576,931	576,931	(1)	576,930	(80,572)	496,358			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		339		339		339		339			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			132,378	132,378		132,378		132,378			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		339	132,378	132,717		132,717		132,717			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,405,562	399,894	3,030,782	6,836,238		6,836,238	(404,693)	6,431,545			45

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

Facility Name & ID Number St Josephs Home F-T Elderly

0027045

Report Period Beginning: 01/01/2015

Ending: 12/31/2015

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(104,528)	1		4
5	Telephone, TV & Radio in Resident Rooms	(6,906)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(10,007)	4		8
9	Non-Straightline Depreciation	(80,572)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions	(116,774)	5		15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(6,287)	6		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance	(7,453)	26		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(72,166)	20		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 See Pages 5A and 5B				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (404,693)		\$	30

BHF USE ONLY						
48		49		50		51
						52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (404,693)		37

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

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

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		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 Josephs Home F-T Elderly

ID# 0027045

Report Period Beginning: 01/01/2015

Ending: 12/31/2015

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	N/A	\$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total		0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number St Josephs Home F-T Elderly# 0027045

Report Period Beginning:

01/01/2015

Ending:

12/31/2015

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(104,528)	0	0	0	0	0	0	0	0	0	0	(104,528)	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	(10,007)	0	0	0	0	0	0	0	0	0	0	(10,007)	4
5	Heat and Other Utilities	(123,680)	0	0	0	0	0	0	0	0	0	0	(123,680)	5
6	Maintenance	(6,287)	0	0	0	0	0	0	0	0	0	0	(6,287)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(244,502)	0	0	0	0	0	0	0	0	0	0	(244,502)	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	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(72,166)	0	0	0	0	0	0	0	0	0	0	(72,166)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(7,453)	0	0	0	0	0	0	0	0	0	0	(7,453)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(79,619)	0	0	0	0	0	0	0	0	0	0	(79,619)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(324,121)	0	0	0	0	0	0	0	0	0	0	(324,121)	29

STATE OF ILLINOIS

Facility Name & ID Number St Josephs Home F-T Elderly

0027045

Report Period Beginning:

01/01/2015 Ending:

Summary B

12/31/2015

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

	Capital Expense	PAGES	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	(80,572)	0	0	0	0	0	0	0	0	0	0	(80,572)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(80,572)	0	0	0	0	0	0	0	0	0	0	(80,572)	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
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(404,693)	0	0	0	0	0	0	0	0	0	0	(404,693)	45

Facility Name & ID Number

St Josephs Home F-T Elderly

0027045

Report Period Beginning:

01/01/2015

Ending:

12/31/2015

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								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

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									\$	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 Josephs Home F-T Elderly

0027045

Report Period Beginning: 01/01/2015

Ending: 2/31/2015

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization N/A
 Street Address _____
 City / State / Zip Code _____
 Phone Number (____) _____
 Fax Number (____) _____

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	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	Name of Lender	2		3	4	5	6		8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required				Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
A. Directly Facility Related																	
Long-Term																	
1	Little Sisters of the Poor						\$	\$			\$						
2	- Chicago Province, Inc.	X		Construction	NONE	Various	2,517,300	2,517,300	Various	0.0300							
3																	
4																	
5																	
Working Capital																	
6	Little Sisters of the Poor																
7	- Chicago Province, Inc.	X		Working Capital	NONE	Various	3,440,310	3,440,310	Various	0.0300							
8																	
9	TOTAL Facility Related						\$ 5,957,610	\$ 5,957,610			\$						
B. Non-Facility Related*																	
10	Little Sisters of the Poor																
11	- Chicago Province, Inc.	X		Convent Allocation	NONE	Various	1,142,390	1,142,390	Various	0.0300							
12																	
13																	
14	TOTAL Non-Facility Related						\$ 1,142,390	\$ 1,142,390			\$						
15	TOTALS (line 9+line14)						\$ 7,100,000	\$ 7,100,000			\$						

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

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1.	Real Estate Tax accrual used on 2014 report.	\$			1
2.	Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$			2
3.	Under or (over) accrual (line 2 minus line 1).	\$			3
4.	Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)	\$			4
5.	Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$			5
6.	Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$			6
7.	Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$			7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2010	_____	8	
		2011	_____	9	
		2012	_____	10	
		2013	_____	11	
		2014	_____	12	
FOR BHF USE ONLY					
		13	FROM R. E. TAX STATEMENT FOR 2014 \$		13
		14	PLUS APPEAL COST FROM LINE 5 \$		14
		15	LESS REFUND FROM LINE 6 \$		15
		16	AMOUNT TO USE FOR RATE CALCULATION \$		16

NOTES:

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

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME St Josephs Home F-T Elderly COUNTY Cook
 FACILITY IDPH LICENSE NUMBER 0027045
 CONTACT PERSON REGARDING THIS REPORT Mother of the Home
 TELEPHONE (847) 358-5700 FAX #: (847) 358-5719

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2014 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2014.

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

B. Real Estate Tax Cost Allocations

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

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

C. **Tax Bills**

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

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 119,979 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 3

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

34 APTS. INDEPENDENT LIVING FACILITIES - NOT a separate entity. Facility is NOT run as a business, but is a part of the mission of the Little Sister of the Poor - taking care of the elderly poor. See page 23A for additional information. Expenses for the apartments are NOT included in this cost report

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

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

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Existing Structure</u>	<u>653,400</u>	<u>1966</u>	<u>\$ 76,284</u>	1
2					2
3	TOTALS	653,400		\$ 76,284	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	64	1966	1966	\$ 3,221,573	\$	40	\$	\$	\$ 3,221,573	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Health Related Renovation		1967	24,177		40			24,177	9
10	Health Related Renovation		1968	34,542		40			34,542	10
11	Health Related Renovation		1969	26,308		40			26,308	11
12	Health Related Renovation		1970	40,716		40			40,716	12
13	Health Related Renovation		1971	22,307		40			22,307	13
14	Health Related Renovation		1972	119,419		40			119,419	14
15	Health Related Renovation		1974	10,272		40			10,272	15
16	Health Related Renovation		1975	9,671	57	40		(57)	9,671	16
17	Health Related Renovation		1976	965	29	40	10	(19)	965	17
18	Health Related Renovation		1978	44,279	1,319	40	1,107	(212)	42,744	18
19	Interior Renovation - Conversion from Wards to Rooms		1983	3,663,633	109,154	40	91,591	(17,563)	3,043,189	19
20	New Fire Door System		1984	25,217	751	40	630	(121)	20,096	20
21	Complete Boiler Renovation		1985	470,291	14,012	40	11,757	(2,255)	362,745	21
22	Electrical Repairs & New Cooling System for Boilers		1987	106,618	3,177	40	2,666	(511)	76,723	22
23	Concrete Restoration		1990	111,172	3,312	40	2,779	(533)	71,431	23
24	Exterior Renovation Including New Windows		1991	317,750	9,467	40	7,944	(1,523)	195,888	24
25	Driveway Restored		1991	32,334		10			32,334	25
26	Sewer Renovation		1992	13,999	417	40	350	(67)	8,258	26
27	Asbestos Removal & Central Air Conditioning		1992	1,051,235	31,320	40	26,281	(5,039)	629,621	27
28	Remodel Center & West Wings		1993	2,619,173	78,035	40	65,479	(12,556)	1,467,702	28
29	Pond Dredge		1995	24,711		14			24,711	29
30	Back Driveway Replaced		1996	57,358		10			57,358	30
31	Patio and Sidewalk Restoration		1998	27,055		10			27,055	31
32	Asphalt Paving		1998	1,888		10			1,888	32
33	Front Walkway Lighting Restoration		1998	2,892		10			2,892	33
34	Brick Paving, Concrete and Electric for Front Walkway/Sitting Area		2000	11,634		10			11,634	34
35	Evergreens, Statue and Pedestal		2003	6,168	368	20	309	(59)	3,858	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

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	Handicap Switches to Front Door	2004	\$ 1,326	\$ 40	40	\$ 34	\$ (6)	\$ 359	37
38	New Flooring	2006	1,339	40	40	34	(6)	322	38
39	Asphalt Replacement	2008	7,063	842	10	706	(136)	5,295	39
40	Garage Roof	2009	13,039	388	40	326	(62)	2,119	40
41	Parking Lot Lights and Poles	2009	35,825	2,135	20	1,791	(344)	11,642	41
42	Concrete and Curb Replacement	2009	15,752	1,877	10	1,575	(302)	10,238	42
43	Building Roof Replacement	2011	757,126	22,558	40	18,928	(3,630)	85,176	43
44	New Parking Lot	2013	135,281	16,122	10	13,528	(2,594)	33,820	44
45	Building Roof Replacement	2013	91,169	2,716	40	2,279	(437)	5,698	45
46	New Flooring Ramp	2014	7,183	214	40	180	(34)	270	46
47	Fire Protection Coating on I Beams	2015	29,453	439	40	368	(71)	368	47
48	Cement Jacking of Sidewalks	2015	7,997	476	10	400	(76)	400	48
49	Trees	2015	8,043	479	10	402	(77)	402	49
50									50
51									51
52									52
53	2010 Cap Bldg Repairs - HVAC, Plumbing and Electric Repairs	2010	24,655		5	2,465	2,465	24,655	53
54	2011 Cap Bldg Repairs - Plumbing and HVAC Repairs	2011	7,424		5	1,485	1,485	6,682	54
55	2012 Cap Bldg Repairs - Plumbing and HVAC Repairs	2012	14,233		5	2,847	2,847	9,964	55
56	2013 Cap Bldg Repairs - HVAC, Plumbing and Electric Repairs	2013	8,036		5	1,607	1,607	4,018	56
57	2014 Cap Bldg Repairs - Plumbing, Flooring and Electric Repairs	2014	16,941		5	3,388	3,388	5,082	57
58	2015 Cap Bldg Repairs - Plumbing Repair	2015	5,275		5	527	527	527	58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 13,284,517	\$ 299,744		\$ 263,773	\$ (35,971)	\$ 9,797,114	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	\$	\$	\$	\$		\$	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	SEE PAGE 13C & 13D							74
75	TOTALS	\$	\$	\$	\$		\$	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	Care Use	1989 M/F Diesel Tractor	1989	\$ 21,817	\$	\$	\$	4	\$ 21,817	76
77	Care Use	1994 Lewis Riding Mower	1994	5,807				4	5,807	77
78	Care Use	1998 Steer-Rite Pallet Truck	1998	470				4	470	78
79	Care Use	1996 Great Chariot Mower	1999	6,521				4	6,521	79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88	SEE PAGE 13C				88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93	SEE PAGE 13C		93
94			94
95		\$	95

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

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

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	\$	\$	\$	\$		\$	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	SEE PAGE 13C & 13D							74
75	TOTALS	\$	\$	\$	\$		\$	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	Care Use	2004 Ford Taurus	2004	\$ 17,647	\$	\$	\$	4	\$ 17,647	76
77	Care Use	2005 John Deere 757 Mower	2005	6,312				4	6,312	77
78	Care Use	2005 Ford E450 Bus	2005	47,077				4	47,077	78
79	Care Use	2006 Chrysler Town & Country	2006	18,627				4	18,627	79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88	SEE PAGE 13C				88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93	SEE PAGE 13C		93
94			94
95		\$	95

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

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

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	\$	\$	\$	\$		\$	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	SEE PAGE 13C & 13D							74
75	TOTALS	\$	\$	\$	\$		\$	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	Care Use	2008 Ford F250 Truck w/Plow	2007	\$ 25,829	\$	\$	\$	4	\$ 25,829	76
77	Care Use	2005 Buick Century	2013	5,747	1,712	1,437	(275)	4	3,592	77
78	Care Use	2003 Ford E350	2013	6,802	2,027	1,700	(327)	4	4,250	78
79	Care Use	2007 Nissan Quest Van	2013	8,069	2,404	2,017	(387)	4	5,043	79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88	SEE PAGE 13C				88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93	SEE PAGE 13C		93
94			94
95		\$	95

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

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 2,185,943	\$ 259,747	\$ 217,952	\$ (41,795)	10 Years	\$ 798,186	71
72	Current Year Purchases	100,152	6,333	5,314	(1,019)	10 Years	5,314	72
73	Fully Depreciated Assets	835,345				10 Years	835,345	73
74								74
75	TOTALS	\$ 3,121,440	\$ 266,080	\$ 223,266	\$ (42,814)		\$ 1,638,845	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	Care Use	2008 Dodge Caravan SE	2013	\$ 8,194	\$ 2,441	\$ 2,049	\$ (392)	4	\$ 5,122	76
77	Care Use	2015 Toyota Camry	2015	16,930	2,522	2,116	(406)	4	2,116	77
78										78
79										79
80	TOTALS			\$ 195,849	\$ 11,106	\$ 9,319	\$ (1,787)		\$ 170,230	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 16,678,090	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 576,930	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 496,358	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (80,572)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 11,606,189	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Bldg - Convent Allocation Various	\$ 2,532,665	\$ 48,290	\$ 1,804,620	86
87	Equip - Convent Allocation Various	598,546	42,814	314,254	87
88	Vehicles - Convent Allocation Various	37,555	1,787	32,642	88
89					89
90					90
91	TOTALS	\$ 3,168,766	\$ 92,891	\$ 2,151,516	91

G. Construction-in-Progress

	Description	Cost	
92	Equipment Upgrades	\$ 70,098	92
93			93
94			94
95		\$ 70,098	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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

If NO, see instructions. YES NO

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

	Fiscal Year Ending	Annual Rent
--	--------------------	-------------

12. _____ /2016 \$ _____

13. _____ /2017 \$ _____

14. _____ /2018 \$ _____

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental? YES NO

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

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number St Josephs Home F-T Elderly # 0027045 Report Period Beginning: 01/01/2015 Ending: 12/31/2015
XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1	
2	Licensed Speech and Language Development Therapist		hrs							2	
3	Licensed Recreational Therapist		hrs							3	
4	Licensed Physical Therapist		hrs							4	
5	Physician Care		visits							5	
6	Dental Care	39 - 2	visits				339		339	6	
7	Work Related Program		hrs							7	
8	Habilitation		hrs							8	
9	Pharmacy		# of prescrpts							9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10	
11	Academic Education		hrs							11	
12	Other (specify):									12	
13	Other (specify):									13	
14	TOTAL			\$		\$	\$ 339		\$ 339	14	

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number **St Josephs Home F-T Elderly**

0027045

Report Period Beginning: **01/01/2015**

Ending:

12/31/2015

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/2015** (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 440,585	\$	1
2	Cash-Patient Deposits	99,298		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 15,000)	469,463		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	367,065		5
6	Prepaid Insurance	21,933		6
7	Other Prepaid Expenses	34,061		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Donations Receivable	158,449		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,590,854	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	111,387		13
14	Buildings, at Historical Cost	15,740,618		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	3,953,390		16
17	Accumulated Depreciation (book methods)	(13,706,777)		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): Construction in Progress	70,098		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 6,168,716	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 7,759,570	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 163,981	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	99,298		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	48,646		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 311,925	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	7,100,000		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)	\$ 7,100,000	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 7,411,925	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 347,645	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 7,759,570	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,726,860	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,726,860	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(1,379,215)	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)	\$ (1,379,215)	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)	\$ 347,645	24 *

* This must agree with page 17, line 47.

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

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

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

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 2,857,605	1
2	Discounts and Allowances for all Levels	(143,617)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,713,988	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions	2,742,675	24
25	Interest and Other Investment Income***	(1,140)	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,741,535	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Gain on disposition of fixed asset	1,500	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,500	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,457,023	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,910,561	31
32	Health Care	2,600,498	32
33	General Administration	1,615,531	33
B. Capital Expense			
34	Ownership	576,931	34
C. Ancillary Expense			
35	Special Cost Centers	339	35
36	Provider Participation Fee	132,378	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,836,238	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,379,215)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,379,215)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,102,343	44
45	Private Pay - Net Inpatient Revenue	312,265	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) <u>MMAI - Net Inpatient Revenue</u>	299,380	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 2,713,988	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.

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

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

Facility Name & ID Number **St Josephs Home F-T Elderly**

0027045

Report Period Beginning: **01/01/2015**

Ending:

12/31/2015

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4	
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing				1
2	Assistant Director of Nursing	1,847	2,154	75,632	35.11
3	Registered Nurses	17,720	19,539	590,604	30.23
4	Licensed Practical Nurses	11,887	13,368	384,450	28.76
5	CNAs & Orderlies	55,141	61,257	956,467	15.61
6	CNA Trainees				6
7	Licensed Therapist				7
8	Rehab/Therapy Aides	3,549	4,237	70,280	16.59
9	Activity Director	1,928	2,177	50,798	23.33
10	Activity Assistants	2,796	3,296	45,220	13.72
11	Social Service Workers	1,862	2,050	47,075	22.96
12	Dietician				12
13	Food Service Supervisor				13
14	Head Cook				14
15	Cook Helpers/Assistants	33,805	37,769	459,981	12.18
16	Dishwashers				16
17	Maintenance Workers	8,501	9,529	196,710	20.64
18	Housekeepers				18
19	Laundry	6,449	6,933	84,657	12.21
20	Administrator				20
21	Assistant Administrator				21
22	Other Administrative				22
23	Office Manager				23
24	Clerical	14,731	16,256	342,418	21.06
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	1,612	1,638	33,238	20.29
32	Other Health Care(specify)				32
33	Other(specify) <u>Security Guards</u>	3,726	4,185	68,032	16.26
34	TOTAL (lines 1 - 33)	165,554	184,388	\$ 3,405,562 *	\$ 18.47

* 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	157	\$ 6,280	1 - 3
36	Medical Director	96	2,400	9 - 3
37	Medical Records Consultant	9	540	10 - 3
38	Nurse Consultant			38
39	Pharmacist Consultant	80	4,406	10 - 3
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant	16	800	11 - 3
45	Social Service Consultant	16	852	12 - 3
46	Other(specify) <u>One Sister Acting</u>			46
47	<u>as Director of Nursing at Stipend +</u>			47
48	<u>Insurance + Room & Board</u>	2,080	45,647	10 - 3
49	TOTAL (lines 35 - 48)	2,454	\$ 60,925	49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			Ownership %	Amount	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function				Description	Amount	Description	Amount		
				Workers' Compensation Insurance	\$ 68,639	IDPH License Fee	\$			
				Unemployment Compensation Insurance	0	Advertising: Employee Recruitment		0		
				FICA Taxes	266,866	Health Care Worker Background Check		664		
				Employee Health Insurance	341,711	(Indicate # of checks performed <u>27</u>)				
				Employee Meals		Patient Background Checks				
				Illinois Municipal Retirement Fund (IMRF)*		Public Relations		72,166		
				Retirement Plan	101,332	Subscriptions		3,729		
				Employee Physicals	3,086	Licenses and Fees		9,522		
				Employee Dental Insurance	10,591	Dues - Life Services Network of IL		3,098		
				Employee Life Insurance	1,811	Dues - Misc		1,389		
						Less: Public Relations Expense		(72,166)		
						Non-allowable advertising	(
						Yellow page advertising	(
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)						TOTAL (agree to Sch. V, line 20, col. 8)		\$ 18,402		
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)						
Description				Amount						
Two Sisters Acting as Administrator and Assistant				\$						
Administrator - Stipend at \$750 for 12 Months Per Sister				18,000						
Health Insurance for 12 Months Per Sister				13,671						
Room and Board for 12 Months Per Sister				57,945						
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				\$ 89,616						
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**			
Vendor/Payee	Type	Amount	Description	Line #	Amount	Description	Amount			
NSN Unemployment	Unemploy Comp Consult	\$ 866			\$	Out-of-State Travel	\$			
LSP - Chicago Provice, Inc.	Payroll Processing	16,827								
Varey & Vaccariello CPAs PC	Accounting & Auditing	40,800				In-State Travel				
LSP - Chicago Province, Inc.	Corporate Compliance	5,661								
Ungaretti & Harris	Legal MMAI (Care Related)	0				Seminar Expense				
LSP - Chicago Province, Inc.	Computer Consulting - IT	7,588								
						Entertainment Expense	(
						(agree to Sch. V, line 24, col. 8)				
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)						TOTAL	\$			
				TOTAL	\$					

* Attach copy of IMRF notifications

**See instructions.

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

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number St Josephs Home F-T Elderly

0027045

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

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 17,535 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 132,378
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? Yes For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? No Indicate the amount. \$ 0
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 25 % for
- d. Have vehicle usage logs been maintained? Yes
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Varey & Vaccariello CPAs PC
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. N/A
Attach invoices and a summary of services for all architect and appraisal fees.