FOR BHF USE

LL1

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.

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

I. IDPH License ID Number: 0046581

Facility Name: St Joseph Village of Chicago

Address: 4021 W Belmont Ave (Number) Chicago (City) 60641 (Zip Code)

County: Cook

Telephone Number: (773) 328 - 5500 **Fax #** (773) 328 - 5502

HFS ID Number:

Date of Initial License for Current Owners: 01/13/06

Type of Ownership:

[X]	VOLUNTARY,NON-PROFIT	[ ]	PROPRIETARY	[ ]	GOVERNMENTAL
[X]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code	501(c)(3)	[ ]	Corporation	[ ]	Other
		[ ]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: Edward N. Slack, CPA **Telephone Number:** (847) 628 - 8796
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/15 to 06/30/16 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) (Date)
(Print Name and Title) Edward N. Slack, CPA, Partner, Health and Human Services
(Firm Name & Address) Plante & Moran, PLLC, 2155 Point Boulevard, Suite 200 Elgin, Illinois 60123
(Telephone) (847) 628 - 8796 Fax # (248) 327 - 8417

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number St Joseph Village of Chicago # 0046581 Report Period Beginning: 07/01/15 Ending: 06/30/16

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	54	Skilled (SNF)	54	19,764	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	54	TOTALS	54	19,764	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	2,117	7,733	6,600	16,450	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	2,117	7,733	6,600	16,450	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.23%

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)
N/A

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 [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 01/13/06

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 01/13/06 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 54 and days of care provided

Medicare Intermediary National Government Services, Inc.

IV. ACCOUNTING BASIS

ACCRUAL	MODIFIED CASH*	CASH*
[X]	[ ]	[ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 06/30/16 Fiscal Year: 06/30/16

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number St Joseph Village of Chicago # 0046581 Report Period Beginning: 07/01/15 Ending: 06/30/16

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	240,808	51,398	242,476	534,682		534,682	(200,874)	333,808			1
2	Food Purchase		231,049		231,049		231,049	(94,075)	136,974			2
3	Housekeeping	151,341	18,500		169,841		169,841	(85,519)	84,322			3
4	Laundry	33,040	14,536		47,576		47,576	(17,874)	29,702			4
5	Heat and Other Utilities			232,245	232,245		232,245	(119,298)	112,947			5
6	Maintenance	83,105	15,170	89,028	187,303		187,303	(94,178)	93,125			6
7	Other (specify):* See Supplemental											7
8	**TOTAL General Services**	508,294	330,653	563,749	1,402,696		1,402,696	(611,818)	790,878			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000	(2,622)	9,378			9
10	Nursing and Medical Records	1,904,545	61,685	5,572	1,971,802		1,971,802	(73,715)	1,898,087			10
10a	Therapy	40,798		2,100	42,898		42,898		42,898			10a
11	Activities	104,192	4,242	2,821	111,255		111,255	(41,797)	69,458			11
12	Social Services	51,762	3,606	25,430	80,798		80,798	(30,355)	50,443			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* See Supplemental											15
16	**TOTAL Health Care and Programs**	2,101,297	69,533	47,923	2,218,753		2,218,753	(148,489)	2,070,264			16
	C. General Administration											
17	Administrative	149,015		575,472	724,487		724,487	(236,971)	487,516			17
18	Directors Fees											18
19	Professional Services			44,360	44,360		44,360	(15,792)	28,568			19
20	Dues, Fees, Subscriptions & Promotions			55,007	55,007		55,007	(12,168)	42,839			20
21	Clerical & General Office Expenses	237,894	20,303	146,975	405,172		405,172	(172,060)	233,112			21
22	Employee Benefits & Payroll Taxes			956,520	956,520		956,520		956,520			22
23	Inservice Training & Education			5,044	5,044		5,044	(1,895)	3,149			23
24	Travel and Seminar			925	925		925	(348)	577			24
25	Other Admin. Staff Transportation			1,615	1,615		1,615	(607)	1,008			25
26	Insurance-Prop.Liab.Malpractice			148,481	148,481		148,481	(34,575)	113,906			26
27	Other (specify):* See Supplemental											27
28	**TOTAL General Administration**	386,909	20,303	1,934,399	2,341,611		2,341,611	(474,416)	1,867,195			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,996,500	420,489	2,546,071	5,963,060		5,963,060	(1,234,723)	4,728,337			29

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number St Joseph Village of Chicago #0046581 Report Period Beginning: 07/01/15 Ending: 06/30/16

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			836,915	836,915		836,915	(421,408)	415,507			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			857,098	857,098		857,098	(432,850)	424,248			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			7,979	7,979		7,979	(2,998)	4,981			35
36	Other (specify):* See Supplemental											36
37	**TOTAL Ownership**			1,701,992	1,701,992		1,701,992	(857,256)	844,736			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		331,285	754,200	1,085,485		1,085,485		1,085,485			39
40	Barber and Beauty Shops			16,921	16,921		16,921	(16,921)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			95,809	95,809		95,809		95,809			42
43	Other (specify):* See Supplemental	654,280	53,328	78,383	785,991		785,991	(785,991)				43
44	**TOTAL Special Cost Centers**	654,280	384,613	945,313	1,984,206		1,984,206	(802,912)	1,181,294			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,650,780	805,102	5,193,376	9,649,258		9,649,258	(2,894,891)	6,754,367			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

St Joseph Village of Chicago
Medicaid Cost Report
07/01/15 - 06/30/16

Page 4 Supplemental Schedule

Description	Salaries	Supplies	Other	Total
Line 36 - Other Capital Costs				
				-
				-
				-
				-
				-
				-
				-
Sub-Total	-	-	-	-
Line 43 - Other Special Cost Centers				
Assisted Living	529,079	24,358	2,994	556,431
Marketing	59,392	28,970	75,389	163,751
Mission Integration	65,809			65,809
				-
				-
				-
				-
Sub-Total	654,280	53,328	78,383	785,991

Facility Name & ID Number St Joseph Village of Chicago # 0046581 Report Period Beginning: 07/01/15 Ending: 06/30/16

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	(5,024)	02		4
5	Telephone, TV & Radio in Resident Rooms	(6,698)	21		5
6	Rented Facility Space	(700)	06		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(2,578)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(92,579)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule Supplemental Schedule	(2,653,090)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (2,760,669)		$	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)	(134,222)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (134,222)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (2,894,891)		37

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

St Joseph Village of Chicago

ID# 0046581

Report Period Beginning: 07/01/15

Ending: 06/30/16

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Snack Shop Revenue	$ (11,357)	02	1
2	Barber and Beauty (To Extent of Expense)	(16,921)	40	2
3	Transportation Revenue	(4,180)	06	3
4	Other Revenue	(1,746)	21	4
5	Cable	(4,748)	05	5
6	Collections / Legal Fees	(7,120)	19	6
7	Bank Fees	(502)	21	7
8	Entertainment and Gifts	(816)	21	8
9	Assisted Living	(556,431)	43	9
10	Marketing	(163,751)	43	10
11	Mission Integration	(65,809)	43	11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23	AL / IL Allocations - See Pg 5 SUPP			23
24				24
25	Dietary - Indirect Allocation	(200,874)	01	25
26	Food Purchases - Indirect Allocation	(77,694)	02	26
27	Housekeeping - Indirect Allocation	(85,519)	03	27
28	Laundry - Indirect Allocation	(17,874)	04	28
29	Heat and Other Utilities - Indirect Allocation	(114,550)	05	29
30	Maintenance - Indirect Allocation	(89,298)	06	30
31	Medical Director - Indirect Allocation	(2,622)	09	31
32	Nursing and Medical Records - Indirect Allocation	(73,715)	10	32
33	Rehab Aides - Indirect Allocation	0	10a	33
34	Activities - Indirect Allocation	(41,797)	11	34
35	Social Services - Indirect Allocation	(30,355)	12	35
36	Program Transportation - Indirect Allocation	0	14	36
37	Administrative - Indirect Allocation	(102,749)	17	37
38	Professional Fees - Indirect Allocation	(8,672)	19	38
39	Dues and Subscriptions - Indirect Allocation	(12,168)	20	39
40	Clerical & General Office - Indirect Allocation	(69,719)	21	40
41	Inservice Training and Education - Indirect Alloc	(1,895)	23	41
42	Travel and Seminar - Indirect Allocation	(348)	24	42
43	Other Admin Staff Transportation - Indirect Alloc	(607)	25	43
44	Insurance - Indirect Allocation	(34,575)	26	44
45	Depreciation - Indirect Allocation	(421,408)	30	45
46	Amortization - Indirect Allocation	0	31	46
47	Interest - Indirect Allocation	(430,272)	32	47
48	Rent - Equipment - Indirect Alloc	(2,998)	35	48
49	**Total**	(2,653,090)		49

St Joseph Village of Chicago
Medicaid Cost Report
07/01/15 - 06/30/16

Page 5 - Non-Care Supplemental Allocation Schedule

				Direct Nursing Home				Statistics		Expenses	
Desciption	Cost Center	Salary	Total Allow. Exp.	Salary	Other	Expenses For Alloc.	Alloc. Method	Nursing Home	Total	Nursing Home	Other
Dietary	1	240,808	534,682			534,682	Meals Served	49,350	79,047	333,808	200,874
Food	2	-	214,668		7,864	206,804	Meals Served	49,350	79,047	136,974	77,694
Housekeeping	3	151,341	169,841			169,841	SQFT (1)	46,408	93,475	84,322	85,519
Laundry	4	33,040	47,576			47,576	Pat. Days (1)	16,450	26,349	29,702	17,874
Heat and Other Utilities	5	-	227,497			227,497	SQFT	46,408	93,475	112,947	114,550
Maintenance	6	83,105	182,423		5,078	177,345	SQFT	46,408	93,475	93,125	89,298
Other	7	-	-			-	Pat. Days	16,450	26,349	-	-
Medical Director	9	-	12,000			12,000	Dir. Staffing	1,618,008	2,070,301	9,378	2,622
Nursing and Medical Records	10	1,904,545	1,971,802	1,577,210	57,175	337,417	Dir. Staffing	1,618,008	2,070,301	1,898,087	73,715
Therapy	10a	40,798	42,898	40,798	2,100	-	Dir. Staffing	1,618,008	2,070,301	42,898	-
Activities	11	104,192	111,255			111,255	Pat. Days (2)	16,450	26,349	69,458	41,797
Social Services	12	51,762	80,798			80,798	Pat. Days (3)	16,450	26,349	50,443	30,355
CNA Training	13	-	-			-	Dir. Staffing				-
Transportation	14	-	-			-	Pat. Days	16,450	26,349	-	-
Other	15	-	-			-	Pat. Days	16,450	26,349	-	-
Administrative	17	149,015	590,265	149,015		441,250	Net. Pat. Rev.	6,721,293	8,761,490	487,516	102,749
Directors Fees	18	-	-			-	N/A				-
Professional Fees	19	-	37,240			37,240	Net. Pat. Rev.	6,721,293	8,761,490	28,568	8,672
Dues and Subscriptions	20	-	55,007		2,753	52,254	Net. Pat. Rev.	6,721,293	8,761,490	42,839	12,168
Office and Clerical	21	237,894	302,831		3,427	299,404	Net. Pat. Rev.	6,721,293	8,761,490	233,112	69,719
Employee Benefits	22	-	956,520			956,520	Alloc. Salary	2,590,071	3,650,780	678,610	277,910
Inservice Training and Expense	23	-	5,044			5,044	Pat. Days	16,450	26,349	3,149	1,895
Travel and Seminar	24	-	925			925	Pat. Days	16,450	26,349	577	348
Other Staff Transportation	25	-	1,615			1,615	Pat. Days	16,450	26,349	1,008	607
Insurance	26	-	148,481			148,481	Net. Pat. Rev.	6,721,293	8,761,490	113,906	34,575
Other	27	-	-			-	N/A				-
Depreciation	30	-	836,915			836,915	SQFT	46,408	93,475	415,507	421,408
Amortization	31	-	-			-	Net. Pat. Rev.	46,408	93,475	-	-
Interest	32	-	854,520			854,520	SQFT	46,408	93,475	424,248	430,272
Real Estate Taxes	33	-	-			-	SQFT	46,408	93,475	-	-
Rent - Facilities and Grounds	34	-	-			-	SQFT			-	-
Rent - Equipment and Vehicles	35	-	7,979			7,979	Pat. Days	16,450	26,349	4,981	2,998
Other	36	-	-			-	N/A				-
Medically Necessary Transportation	38	-	-			-	N/A				-
Ancillary Service Centers	39	-	1,085,485		1,085,485	-	Direct	1	1	1,085,485	-
Barber and Beauty Shop	40	-	-			-	Direct			-	-
Coffee and Gift Shops	41	-	-			-	Direct			-	-
Provider Participation Fee	42	-	95,809		95,809	-	Direct	1	1	95,809	-
Other	43	654,280	-			-	Direct	-	1	-	-
		3,650,780	8,574,076	1,767,023	1,259,691	5,547,362				6,476,457	2,097,619

STATE OF ILLINOIS

Summary A

Facility Name & ID Number St Joseph Village of Chicago # 0046581 **Report Period Beginning:** 07/01/15 **Ending:** 06/30/16

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	(200,874)	0	0	0	0	0	0	0	0	0	0	(200,874)	1
2	Food Purchase	(94,075)	0	0	0	0	0	0	0	0	0	0	(94,075)	2
3	Housekeeping	(85,519)	0	0	0	0	0	0	0	0	0	0	(85,519)	3
4	Laundry	(17,874)	0	0	0	0	0	0	0	0	0	0	(17,874)	4
5	Heat and Other Utilities	(119,298)	0	0	0	0	0	0	0	0	0	0	(119,298)	5
6	Maintenance	(94,178)	0	0	0	0	0	0	0	0	0	0	(94,178)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(611,818)	0	0	0	0	0	0	0	0	0	0	(611,818)	8
	B. Health Care and Programs													
9	Medical Director	(2,622)	0	0	0	0	0	0	0	0	0	0	(2,622)	9
10	Nursing and Medical Records	(73,715)	0	0	0	0	0	0	0	0	0	0	(73,715)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(41,797)	0	0	0	0	0	0	0	0	0	0	(41,797)	11
12	Social Services	(30,355)	0	0	0	0	0	0	0	0	0	0	(30,355)	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**	(148,489)	0	0	0	0	0	0	0	0	0	0	(148,489)	16
	C. General Administration													
17	Administrative	(102,749)	(134,222)	0	0	0	0	0	0	0	0	0	(236,971)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(15,792)	0	0	0	0	0	0	0	0	0	0	(15,792)	19
20	Fees, Subscriptions & Promotions	(12,168)	0	0	0	0	0	0	0	0	0	0	(12,168)	20
21	Clerical & General Office Expenses	(172,060)	0	0	0	0	0	0	0	0	0	0	(172,060)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	(1,895)	0	0	0	0	0	0	0	0	0	0	(1,895)	23
24	Travel and Seminar	(348)	0	0	0	0	0	0	0	0	0	0	(348)	24
25	Other Admin. Staff Transportation	(607)	0	0	0	0	0	0	0	0	0	0	(607)	25
26	Insurance-Prop.Liab.Malpractice	(34,575)	0	0	0	0	0	0	0	0	0	0	(34,575)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(340,194)	(134,222)	0	0	0	0	0	0	0	0	0	(474,416)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(1,100,501)	(134,222)	0	0	0	0	0	0	0	0	0	(1,234,723)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number St Joseph Village of Chicago # 0046581 **Report Period Beginning:** 07/01/15 **Ending:** 06/30/16

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(421,408)	0	0	0	0	0	0	0	0	0	0	(421,408)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(432,850)	0	0	0	0	0	0	0	0	0	0	(432,850)	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	(2,998)	0	0	0	0	0	0	0	0	0	0	(2,998)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(857,256)	0	0	0	0	0	0	0	0	0	0	(857,256)	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	(16,921)	0	0	0	0	0	0	0	0	0	0	(16,921)	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):*	(785,991)	0	0	0	0	0	0	0	0	0	0	(785,991)	43
44	**TOTAL Special Cost Centers**	(802,912)	0	0	0	0	0	0	0	0	0	0	(802,912)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(2,760,669)	(134,222)	0	0	0	0	0	0	0	0	0	(2,894,891)	45

Facility Name & ID Number St Joseph Village of Chicago # 0046581 Report Period Beginning: 07/01/15 Ending: 06/30/16

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Page 6 - Supp		See Page 6 - Supp		See Page 6 - Supp		

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	FSCSC Shared Expenses	$ 575,472	Franciscan Sisters of Chicago Service Corporation	100.00%	$ 441,250	$ (134,222)	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 575,472			$ 441,250	$ * (134,222)	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number St Joseph Village of Chicago # 0046581 Report Period Beginning: 07/01/15 Ending: 06/30/16

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Franciscan Communities, Inc.		St. Joseph Village of Chicago	Chicago, IL	Franciscan Sisters			1
2			The Village at Victory Lakes	Lindenhurst, IL	of Chicago	Lemont, IL	Religious Cong.	2
3			Addolorata Villa	Wheeling, IL	Franciscan Sisters			3
4	Board of Directors Listing		Franciscan Village	Lemont, IL	Chicago Serv Crp	Lemont, IL	Corp. Management	4
5			St. Anthony Home	Crown Point, IN	St. James			5
6	Sister M. Francis Clare Radke		University Place	West Lafayette, IN	Senior Estates	Crete, IL	Ind. Living	6
7	James Stark		Mount Alverna Village	Parma, OH	Marian Village	Homer Glen, IL	Ind. & Ast. Living	7
8	Judy Amiano				Franciscan			8
9	Andrew Duren				Senior Estates	Louisville, KY	Ind. Living	9
10	Tracy Shearer				Franciscan Comm.			10
11	Ronald Tinsley				Based Services	Michigan City, IN	Hm. Care / Hospice	11
12	Denise Bourdreau				Franciscan Advisory			12
13					Services	Lemont, IL	Consulting Serv.	13
14					St. Joseph			14
15					Senior Housing	Lemont, IL	Affordable Housing	15
16					St. Jude House	Crown Point, IN	Dom. Viol. Shelter	16
17					Madonna Found.	Lemont, IL	HS Schol. Found.	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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number St Joseph Village of Chicago # 0046581 Report Period Beginning: 07/01/15 Ending: 06/30/16

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Judy Amiano	Board Member	President & CEO	0.00%	See Supplemental	2.39	5.97%	Alloc. Salary	$ 11,945	17 - 03	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	$ 11,945		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

SEE ACCOUNTANTS' PREPARATION REPORT

St Joseph Village of Chicago
Medicaid Cost Report
07/01/15 - 06/30/16

Page 7 Supplemental Schedule

				Total Compensation			Alloc. Compensation	
Desciption	**Alloc. Hours**	**Total Hours**	**Alloc. Percentage**	**Salary**	**Mgmt. Fees**		**Salary**	**Mgmt. Fees**
Owners / Director Compensation - Judy Amiano (President & CEO)								
Addolorata Villa	4.99	40	12.47%	200,000	-		24,942	-
Franciscan Village	5.86	40	14.65%	200,000	-		29,304	-
St. Joseph Village	2.39	40	5.97%	200,000	-		11,945	-
Village at Victory Lakes	5.99	40	14.98%	200,000	-		29,950	-
Other	20.77	40	51.93%	200,000	-		103,858	-
							-	-
							-	-
							-	-
							-	-
							-	-
							-	-
							-	-
							-	-
							-	-
							-	-
							-	-
							-	-
							-	-
							-	-
							-	-
							-	-
							-	-
							-	-
							-	-
							-	-
							-	-
							-	-
							-	-
Total	40.00		100.00%				200,000	-

Facility Name & ID Number St Joseph Village of Chicago # 0046581 Report Period Beginning: 07/01/15 Ending: 06/30/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Franciscan Sisters of Chicago Serv Corporation
Street Address: 1055 West 175th Street
City / State / Zip Code: Homewood, Illinois 60430
Phone Number: ( )
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	FSCSC Shared Expenses	Management Fees	9,635,364	13	$ 7,350,174	$ 3,855,135	575,472	$ 438,989	1
2	17	FSCSC Shared Expenses	Health Premiums	8,323,800	13	43,580	0	431,829	2,261	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					$ 7,393,754	$ 3,855,135		$ 441,250	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number St Joseph Village of Chicago # 0046581 Report Period Beginning: 07/01/15 Ending: 06/30/16

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Amalgamated Bank		X	Facility Acquisition	Varies	07/01/03	$ 3,060,000	$ 3,060,000		7.4000%	$ 173,992	1
2	Amalgamated Bank		X	Facility Acquisition	Varies	03/13/13	9,664,936	9,166,915	05/15/47	4.8600%	521,233	2
3	Huntington Bank		X	Facility Acquisition	Varies	03/13/13	1,240,627	1,157,826	05/15/43	Variable	65,834	3
4	Huntington Bank		X	Facility Acquisition	Varies	03/13/13	1,819,992	1,689,033	05/15/43	Variable	96,039	4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 15,785,555	$ 15,073,773			$ 857,098	9
	B. Non-Facility Related*											
10	Interest Income										(2,578)	10
11												11
12	Allocation - IL / AL										(430,272)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (432,850)	14
15	TOTALS (line 9+line14)						$ 15,785,555	$ 15,073,773			$ 424,248	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 0 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.)

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number St Joseph Village of Chicago **#** 0046581 **Report Period Beginning:** 07/01/15 **Ending:** 06/30/16

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**		$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2011		8
	2012		9
	2013		10
	2014		11
	2015		12

N/A - St. Joseph Village of Chicago is exempt from real estate taxes.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

SEE ACCOUNTANTS' PREPARATION REPORT

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME St Joseph Village of Chicago COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0046581

CONTACT PERSON REGARDING THIS REPORT Edward N. Slack, CPA

TELEPHONE (847) 628 - 8796 FAX #: (248) 327 - 8417

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2015 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2015.

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

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

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

Facility Name & ID Number St Joseph Village of Chicago # 0046581 Report Period Beginning: 07/01/15 Ending: 06/30/16

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 46,408 B. General Construction Type: Exterior Brick / Masonry Frame Steel Number of Stories 3

C. Does the Operating Entity? [X] (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? [X] (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).

Assisted Living - 42,457 Square Feet
Dr. Offices - 180 Square Feet
Therapy Room - 1,840 Square Feet
Retail Food - 2,590 Square Feet
Chapel - 4,110 Square Feet

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		2003	$ 141,036	1
2					2
3	TOTALS			$ 141,036	3

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number St Joseph Village of Chicago # 0046581 Report Period Beginning: 07/01/15 Ending: 06/30/16

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	54		2006	2006	$ 10,146,462	$		$	$	$	4
5			2007	2007	(315,077)						5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2007	24,402						9
10	Various			2008	29,726						10
11	Various			2009	6,967						11
12	Various			2010	4,092						12
13	Various			2012	14,038						13
14	One Card Reader - Installation (TC = $2,825)			2013	2,825						14
15	Door Closures and Locks - Hallways (TC = $7,404)			2013	7,404						15
16	Nurse Workstations - 3rd Floor (TC = $5,875)			2014	5,875						16
17	Entrance Sign and Lighting - Main Entrance (TC = $14,555)			2014	7,226						17
18	Gazebo (TC = $8,430)			2015	4,185						18
19	Boiler - Boiler Tubes and Head Gaskets Replaced(TC =$3,200)			2015	1,589						19
20	Sidewalk and Landscaping (TC = $8,100)			2015	4,021						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

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

See Page 12A, Line 70 for total

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number St Joseph Village of Chicago # 0046581 Report Period Beginning: 07/01/15 Ending: 06/30/16

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
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									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									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)		$ 9,943,735	$		$	$	$	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number St Joseph Village of Chicago # 0046581 Report Period Beginning: 07/01/15 Ending: 06/30/16

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 9,943,735	$		$	$	$	1
2									2
3	Current Year Additions FY 2015 - 2016								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	TOTAL (lines 1 thru 33)		$ 9,943,735	$		$	$	$	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

St Joseph Village of Chicago
Medicaid Cost Report
07/01/15 - 06/30/16

Page 12D - CY Leasehold Improvement Additions

Desciption	Acquisiton Date	Cost	Class	Method	Capitalized Nursing Home	Capitalized Other	Expensed Nursing Home	Expensed Other
Non-Care	2016	4,340	LIMP	Direct - OTH	-	4,340	-	-
		4,340			-	4,340	-	-

Facility Name & ID Number St Joseph Village of Chicago # 0046581 Report Period Beginning: 07/01/15 Ending: 06/30/16

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 9,943,735	$		$	$	$	1
2									2
3	Dispositions - Prior Years								3
4									4
5									5
6									6
7									7
8									8
9	Dispositions - Current Year								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	Financial Statement Depreciation			415,507		415,507		5,144,374	33
34	TOTAL (lines 1 thru 33)		$ 9,943,735	$ 415,507		$ 415,507	$	$ 5,144,374	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

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Page 12E - CY Leasehold Improvement Dispositions

					Capitalized		Expensed	
Desciption	Acquisiton Date	Cost	Class	Method	Nursing Home	Other	Nursing Home	Other
		-			-	-	-	-

Facility Name & ID Number St Joseph Village of Chicago # 0046581 Report Period Beginning: 07/01/15 Ending: 06/30/16

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	$ 694,796	$	$	$		$	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	Disposals							74
75	TOTALS	$ 694,796	$	$	$		$	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	Bus	2007	$ 22,893	$	$	$		$	76
77	Facility	Bus	2016	34,151						77
78										78
79										79
80	TOTALS			$ 57,044	$	$	$		$	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)	$ 10,836,611	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 415,507	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 415,507	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)	$ 5,144,374	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	Non-Care Assets - PY Total	$ 10,937,135	$	$	86
87	Non-Care Assets - CY LIMP Add.	4,340			87
88	Non-Care Assets - CY EQIP Add.	20,101			88
89	Non-Care Assets - CY Disposals	(10,208)			89
90	Financial Statement Depreciation		421,408	5,217,434	90
91	TOTALS	$ 10,951,368	$ 421,408	$ 5,217,434	91

G. Construction-in-Progress

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

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

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

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Page 13 - CY Equipment, Funiture and Vehicle Additions

					Capitalized		Expensed	
Desciption	**Acquisiton Date**	**Cost**	**Class**	**Method**	**Nursing Home**	**Other**	**Nursing Home**	**Other**
Non-Care	2016	20,101	EQIP	Direct - OTH	-	20,101	-	-
		20,101			-	20,101	-	-

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Page 13 - CY Equipment, Funiture and Vehicle Dispositions

					Capitalized		Expensed	
Desciption	**Acquisiton Date**	**Cost**	**Class**	**Method**	**Nursing Home**	**Other**	**Nursing Home**	**Other**
Non-Care	Various	10,208	EQIP	Direct - OTH	-	10,208	-	-
		10,208			-	10,208	-	-

Facility Name & ID Number St Joseph Village of Chicago # 0046581 Report Period Beginning: 07/01/15 Ending: 06/30/16

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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 [X] 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	See Suppl.				0			5
6								6
7	TOTAL				$ **			7

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

9. Option to Buy: [ ] YES [ ] NO Terms: *

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.	/2017	$
13.	/2018	$
14.	/2019	$

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

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

16. Rental Amount for movable equipment: $ 4,981 Description: See Supplemental Schedule
(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.

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Page 14 Supplemental Schedule

Desciption	Amount	Total
Building Rental		
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
Total	-	-
Equipment Rental		
Copier	5,846	5,846
Postage Machine	628	628
Other	1,505	1,505
		-
		-
		-
		-
		-
		-
		-
		-
Alloc. - IL / AL	(2,998)	(2,998)
		-
Total	4,981	4,981

Facility Name & ID Number St Joseph Village of Chicago # 0046581 Report Period Beginning: 07/01/15 Ending: 06/30/16

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] 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.

SEE ACCOUNTANTS' PREPARATION REPORT

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 234,753	$		$ 234,753	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			90,479			90,479	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			317,376			317,376	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				235,709		235,709	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): See Supplemental	39 - 02					95,576		95,576	12
13	Other (specify): See Supplemental	39 - 03				111,592			111,592	13
14	TOTAL			$		$ 754,200	$ 331,285		$ 1,085,485	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.

SEE ACCOUNTANTS' PREPARATION REPORT

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Page 16 Supplemental Schedule

Description	Salaries	Supplies	Other	Total
Medical Supplies		78,362		78,362
Oxygen and Supplies		17,214		17,214
Medical Equipment Rental			49,939	49,939
Laboratory			7,870	7,870
Radiology			6,929	6,929
Ambulance			29,598	29,598
Respiratory Therapy			605	605
Other			16,651	16,651
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
Total	-	95,576	111,592	207,168

Facility Name & ID Number St Joseph Village of Chicago # 0046581 Report Period Beginning: 07/01/15 Ending: 06/30/16

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/16 (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	$ 748	$	1
2	Cash-Patient Deposits	1,547		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	928,955		3
4	Supply Inventory (priced at Cost - FIFO)	33,035		4
5	Short-Term Investments			5
6	Prepaid Insurance	140,702		6
7	Other Prepaid Expenses	53,647		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Supplemental Schedule	2,792		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,161,426	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	1,348,419		13
14	Buildings, at Historical Cost	15,073,131		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	5,067,973		16
17	Accumulated Depreciation (book methods)	(10,361,808)		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): See Supplemental Schedule	24,990		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 11,152,705	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 12,314,131	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 452,233	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	3,415		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	304,755		30
31	Accrued Taxes Payable (excluding real estate taxes)	3,603		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	See Supplemental Schedule	120,834		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 884,840	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Supplemental Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 884,840	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 11,429,291	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 12,314,131	$	48

SEE ACCOUNTANTS' PREPARATION REPORT

***(See instructions.)**

St Joseph Village of Chicago
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Page 17 Supplemental Schedule

Description	Operating	Building	Total
Line 9 - Other Current Assets			
Other Current Receivables	2,792		2,792
			-
			-
			-
			-
Sub-Total	2,792	-	2,792
Line 23 - Long Term Assets			
Construction in Progress	24,990		24,990
			-
			-
			-
			-
Sub-Total	24,990	-	24,990
Line 36 - Other Current Liability			
Refundable Deposits	86,523		86,523
Unrefundable Deposits (Net of Amort.)	34,311		34,311
			-
			-
			-
Sub-Total	120,834	-	120,834
Line 43 - Long term Liabilities			
			-
			-
			-
			-
			-
Sub-Total	-	-	-

Facility Name & ID Number St Joseph Village of Chicago # 0046581 Report Period Beginning: 07/01/15 Ending: 06/30/16

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 12,048,644	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 12,048,644	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(722,141)	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)**	$ (722,141)	17
	B. Transfers (Itemize):		
18	**FC Holding - Intercompany Transfer**	102,788	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 102,788	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 11,429,291	24 *

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number St Joseph Village of Chicago # 0046581 Report Period Beginning: 07/01/15 Ending: 06/30/16

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,761,490	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,761,490	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	101,057	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 101,057	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	11,357	12
13	Barber and Beauty Care	20,305	13
14	Non-Patient Meals	5,024	14
15	Telephone, Television and Radio	6,698	15
16	Rental of Facility Space	700	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	781	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 44,865	23
	D. Non-Operating Revenue		
24	Contributions	11,201	24
25	Interest and Other Investment Income***	2,578	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 13,779	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	5,926	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 5,926	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,927,117	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,402,696	31
32	Health Care	2,218,753	32
33	General Administration	2,341,611	33
	B. Capital Expense		
34	Ownership	1,701,992	34
	C. Ancillary Expense		
35	Special Cost Centers	1,888,397	35
36	Provider Participation Fee	95,809	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,649,258	40
41	**Income before Income Taxes (line 30 minus line 40)****	(722,141)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (722,141)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 283,690	44
45	Private Pay - Net Inpatient Revenue	2,894,366	45
46	Medicare - Net Inpatient Revenue	2,745,184	46
47	Other-(specify) Insurance - Net Patient Revenue	798,053	47
48	Other-(specify) Private Pay - Assisted and Independent Living	2,040,197	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 8,761,490	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Not Final 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.

SEE ACCOUNTANTS' PREPARATION REPORT

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Page 19 Supplemental Schedule

Description	Amount	Total
Transportation Revenue	4,180	4,180
Miscellaneous Revenue	1,746	1,746
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
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		-
		-
		-
		-
		-
		-
		-
Total	5,926	5,926

Facility Name & ID Number St Joseph Village of Chicago # 0046581 Report Period Beginning: 07/01/15 Ending: 06/30/16

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,936	2,080	$ 101,881	$ 48.98	1
2	Assistant Director of Nursing	1,901	1,967	77,324	39.31	2
3	Registered Nurses	22,972	24,864	863,467	34.73	3
4	Licensed Practical Nurses	4,078	4,415	123,746	28.03	4
5	CNAs & Orderlies	41,705	46,285	589,997	12.75	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,276	1,276	40,798	31.97	8
9	Activity Director	1,936	2,080	50,603	24.33	9
10	Activity Assistants	3,791	4,231	53,589	12.67	10
11	Social Service Workers	1,464	1,874	51,762	27.62	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	3,789	4,201	71,217	16.95	14
15	Cook Helpers/Assistants	14,369	15,421	169,591	11.00	15
16	Dishwashers					16
17	Maintenance Workers	3,526	3,926	83,105	21.17	17
18	Housekeepers	9,950	11,137	151,341	13.59	18
19	Laundry	2,638	2,774	33,040	11.91	19
20	Administrator	1,888	2,098	149,015	71.03	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,219	13,487	234,894	17.42	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	1,929	2,092	28,507	13.63	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	39,407	43,824	773,903	17.66	33
34	TOTAL (lines 1 - 33)	170,774	188,032	$ 3,647,780 *	$ 19.40	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director		12,000	09 - 03	36
37	Medical Records Consultant		1,600	10 - 03	37
38	Nurse Consultant				38
39	Pharmacist Consultant		3,972	10 - 03	39
40	Physical Therapy Consultant		2,100	10a - 03	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant		517	11 - 03	44
45	Social Service Consultant				45
46	Other(specify)				46
47	See Supplemental Schedule		261,655		47
48					48
49	TOTAL (lines 35 - 48)		$ 281,844		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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

St Joseph Village of Chicago
Medicaid Cost Report
07/01/15 - 06/30/16

Page 20 Supplemental Schedule

Description	CC Reference	Hours Worked	Hours Paid	Salary	Average Rate	Hours Paid	Contracted Cost
Nursing Home Employees							
MDS Nurse	10	2,260	2,476	89,482	36.14		
Nursing Admin. Support	10	1,839	1,989	30,141	15.15		
Assisted Living	43	31,648	35,319	529,079	14.98		
Marketing	43	1,724	1,960	59,392	30.30		
Director of Mission Integration	43	1,936	2,080	65,809	31.64		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
Total		39,407	43,824	773,903	17.66		
Contracted Services							
Dietary Management	01						51,029
Dietary Contracted Services	01						189,676
Priest	12						19,250
Organist	12						1,700
Total						-	261,655

Facility Name & ID Number St Joseph Village of Chicago # 0046581 Report Period Beginning: 07/01/15 Ending: 06/30/16

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Brian Celerio	Executive Dir.	0	$ 149,015
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 149,015

B. Administrative - Other

Description	Amount
Franciscan Sisters of Chicago Service Corp	$ 575,472
TOTAL (agree to Schedule V, line 17, col. 3)	$ 575,472
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Plante Moran, PLLC	Accounting	$ 18,100
Probusiness	Payroll Processing	12,937
Ability Network, Inc.	Data Processing	5,894
FMLASource	HR Consultnat	309
Non-Allowable	Collections / Legal	7,120
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 44,360

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 150,539
Unemployment Compensation Insurance	19,373
FICA Taxes	273,239
Employee Health Insurance	299,637
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Dental Insurance	19,958
Vision Insurance	3,229
Disability Insurance	7,329
Life Insurance	3,901
Retirement Benefits	70,658
PTO Benefit Adjustment	87,881
Other Employee Benefits	20,776
TOTAL (agree to Schedule V, line 22, col.8)	$ 956,520

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	2,016
Health Care Worker Background Check	6,093
(Indicate # of checks performed)	
Patient Background Checks	
Dues and Subscriptions	37,107
Licenses	9,751
Inspections	40
Allocation - IL / AL	(12,168)
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 42,839

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	925
Allocation - IL / AL	(348)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 577

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number St Joseph Village of Chicago # 0046581 Report Period Beginning: 07/01/15 Ending: 06/30/16

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **LeadingAge $8,554**

(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? **5 - 10 Yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **19,711** Line **10 - 02**

(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. $ **95,809**
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.

SEE ACCOUNTANTS' PREPARATION REPORT

(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 - See Pg. 11** 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? **Yes** Indicate the amount. $ **5,024**

(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? **Ln 14**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Plante & Moran, PLLC - Consolidated Statement**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes - Alloc. Basis**

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