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.

2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

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: Christopher S. Joos **Telephone Number:** (614) 222 - 9040
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 07/01/16 to 06/30/17 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) Christopher S. Joos, Partner, Health and Human Services
(Firm Name & Address) Plante & Moran, PLLC, 250 South High Street, Suite 100 Columbus, OH 43215
(Telephone) (614) 222 - 9040 Fax # (248) 233 - 8811

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: 07/01/16 Ending: 06/30/17

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	19,710	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	19,710	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	2,086	7,484	6,689	16,259	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	2,086	7,484	6,689	16,259	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.49%

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

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
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 5,048

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: 06/30/17 Fiscal Year: 06/30/17

* 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: 07/01/16 Ending: 06/30/17

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	245,923	47,704	261,205	554,832		554,832	(234,158)	320,674			1
2	Food Purchase		235,647		235,647		235,647	(104,967)	130,680			2
3	Housekeeping	159,763	23,907		183,670		183,670	(92,482)	91,188			3
4	Laundry	34,546	11,389		45,935		45,935	(19,348)	26,587			4
5	Heat and Other Utilities			232,178	232,178		232,178	(116,907)	115,271			5
6	Maintenance	79,336	19,206	84,869	183,411		183,411	(87,450)	95,961			6
7	Other (specify):* See Supplemental							833	833			7
8	**TOTAL General Services**	519,568	337,853	578,252	1,435,673		1,435,673	(654,479)	781,194			8
	B. Health Care and Programs											
9	Medical Director			13,200	13,200		13,200	(3,488)	9,712			9
10	Nursing and Medical Records	1,924,061	56,104	5,031	1,985,196		1,985,196	(28,361)	1,956,835			10
10a	Therapy	11,029		13	11,042		11,042		11,042			10a
11	Activities	106,651	3,621	2,312	112,584		112,584	(47,421)	65,163			11
12	Social Services	132,833	3,063	20,434	156,330		156,330	(65,847)	90,483			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* See Supplemental							3,542	3,542			15
16	**TOTAL Health Care and Programs**	2,174,574	62,788	40,990	2,278,352		2,278,352	(141,575)	2,136,777			16
	C. General Administration											
17	Administrative	130,810		591,132	721,942		721,942	(616,246)	105,696			17
18	Directors Fees											18
19	Professional Services			67,040	67,040		67,040	(3,174)	63,866			19
20	Dues, Fees, Subscriptions & Promotions			53,840	53,840		53,840	(4,653)	49,187			20
21	Clerical & General Office Expenses	222,274	19,874	199,049	441,197		441,197	(37,888)	403,309			21
22	Employee Benefits & Payroll Taxes			820,704	820,704		820,704	(31,474)	789,230			22
23	Inservice Training & Education			5,351	5,351		5,351	(425)	4,926			23
24	Travel and Seminar			1,258	1,258		1,258	19	1,277			24
25	Other Admin. Staff Transportation			1,509	1,509		1,509	1,814	3,323			25
26	Insurance-Prop.Liab.Malpractice			147,695	147,695		147,695	(38,194)	109,501			26
27	Other (specify):* See Supplemental							35,234	35,234			27
28	**TOTAL General Administration**	353,084	19,874	1,887,578	2,260,536		2,260,536	(694,987)	1,565,549			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,047,226	420,515	2,506,820	5,974,561		5,974,561	(1,491,041)	4,483,520			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.

St Joseph Village of Chicago
Medicaid Cost Report
07/01/16 - 06/30/17

Page 3 Supplemental Schedule

Description	Salaries	Supplies	Other	Total
Line 7 - Other General Services				
Franciscan Sisters of Chicago Serv Corp				-
Alloc. - Employee Benefits			1,440	1,440
				-
Alloc. - Non-Allowable AL			(607)	(607)
				-
				-
				-
Sub-Total	-	-	833	833
Line 15 - Other Health Care Services				
Franciscan Sisters of Chicago Serv Corp				-
Alloc. - Employee Benefits			6,119	6,119
				-
Alloc. - Non-Allowable AL			(2,577)	(2,577)
				-
				-
				-
Sub-Total	-	-	3,542	3,542
Line 27 - Other General Administration				
Franciscan Sisters of Chicago Serv Corp				-
Alloc. - Employee Benefits			51,420	51,420
				-
Alloc. - Non-Allowable AL			(16,186)	(16,186)
				-
				-
				-
Sub-Total	-	-	35,234	35,234

Facility Name & ID Number St Joseph Village of Chicago #0046581 Report Period Beginning: 07/01/16 Ending: 06/30/17

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			768,667	768,667		768,667	(379,810)	388,857			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			862,898	862,898		862,898	(437,389)	425,509			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds							4,432	4,432			34
35	Rent-Equipment & Vehicles			596	596		596	395	991			35
36	Other (specify):* See Supplemental											36
37	**TOTAL Ownership**			1,632,161	1,632,161		1,632,161	(812,372)	819,789			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		341,532	734,604	1,076,136		1,076,136		1,076,136			39
40	Barber and Beauty Shops			15,751	15,751		15,751	(15,751)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			97,911	97,911		97,911		97,911			42
43	Other (specify):* See Supplemental	698,503	36,723	219,929	955,155		955,155	(955,155)				43
44	**TOTAL Special Cost Centers**	698,503	378,255	1,068,195	2,144,953		2,144,953	(970,906)	1,174,047			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,745,729	798,770	5,207,176	9,751,675		9,751,675	(3,274,319)	6,477,356			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
07/01/16 - 06/30/17

Page 4 Supplemental Schedule

Description	Salaries	Supplies	Other	Total
Line 36 - Other Capital Costs				
				-
				-
				-
				-
				-
				-
				-
Sub-Total	-	-	-	-
Line 43 - Other Special Cost Centers				
Assisted Living	625,359	23,867	114,197	763,423
Marketing	73,144	12,587	102,947	188,678
Development		269	2,785	3,054
				-
				-
				-
				-
Sub-Total	698,503	36,723	219,929	955,155

Facility Name & ID Number St Joseph Village of Chicago # 0046581 Report Period Beginning: 07/01/16 Ending: 06/30/17

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	(12,404)	02		4
5	Telephone, TV & Radio in Resident Rooms	(5,133)	21		5
6	Rented Facility Space	(75)	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	(5,838)	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	(128,995)	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 See Supplemental	(2,944,249)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (3,096,694)		$	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)	(177,625)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (177,625)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (3,274,319)		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: 07/01/16

Ending: 06/30/17

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Beauty Shop Revenue	$ (15,751)	40	1
2	Transportation Revenue	(7,731)	06	2
3	Insurance Settlements	(8,612)	26	3
4	Miscellaneous Revenue	(291)	21	4
5	Fixed Assets Expensed < $2,500	3,313	06	5
6	Fixed Assets Expensed < $2,500		43	6
7	Collections	(14,603)	19	7
8	Bank Fees	(66)	21	8
9	Cable	(6,953)	21	9
10	Credit Card Fees	(1,201)	21	10
11	Gifts	(458)	21	11
12	Assisted Living	(763,423)	43	12
13	Marketing	(188,678)	43	13
14	Development	(3,054)	43	14
15	Page 5 SUPP - Assisted Living Allocations			15
16	Dietary	(234,158)	01	16
17	Food	(92,563)	02	17
18	Housekeeping	(92,482)	03	18
19	Laundry	(19,348)	04	19
20	Utilities	(116,907)	05	20
21	Maintenance	(92,132)	06	21
22	Other	(607)	07	22
23	Medical Director	(3,488)	09	23
24	Nursing and Medical Records	(57,314)	10	24
25	Therapy	0	10A	25
26	Activities	(47,421)	11	26
27	Social Services	(65,847)	12	27
28	CNA Training	0	13	28
29	Transportation	0	14	29
30	Other	(2,577)	15	30
31	Administrative	(37,294)	17	31
32	Director Fees	0	18	32
33	Professional Fees	(22,535)	19	33
34	Dues and Subscriptions	(16,442)	20	34
35	Clerical	(141,562)	21	35
36	Employee Benefits (Not ADJ - Rate Calculation)	0	22	36
37	Inservice Training	(4,795)	23	37
38	Seminar and Travel	(930)	24	38
39	Other Staff Admin. Transportation	(2,370)	25	39
40	Insurance	(38,637)	26	40
41	Other	(16,186)	27	41
42	Depreciation	(394,378)	30	42
43	Amortization	0	31	43
44	Interest	(431,551)	32	44
45	Real Estate Taxes	0	33	45
46	Rent - Building	(4,495)	34	46
47	Rent - Equipment	(722)	35	47
48	Other	0	36	48
49	**Total**	(2,944,249)		49

St Joseph Village of Chicago
Medicaid Cost Report
07/01/16 - 06/30/17

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	Other	Nursing Home	Other
Dietary	1	245,923	554,832	-	3,012	551,820	Meals Served	48,777	84,732	320,674	234,158
Food	2	-	223,243	-	5,109	218,134	Meals Served	48,777	84,732	130,680	92,563
Housekeeping	3	159,763	183,670	-	-	183,670	SQFT	46,408	93,475	91,188	92,482
Laundry	4	34,546	45,935	-	-	45,935	Pat. Days	16,259	28,091	26,587	19,348
Heat and Other Utilities	5	-	232,178	-	-	232,178	SQFT	46,408	93,475	115,271	116,907
Maintenance	6	79,336	188,093	-	5,119	182,974	SQFT	46,408	93,475	95,961	92,132
Other	7	-	1,440	-	-	1,440	Pat. Days	16,259	28,091	833	607
Medical Director	9	-	13,200	-	-	13,200	Dir. Staffing	1,741,154	2,366,513	9,712	3,488
Nursing and Medical Records	10	1,924,061	2,014,149	1,741,154	56,104	216,891	Dir. Staffing	1,741,154	2,366,513	1,956,835	57,314
Therapy	10a	11,029	11,042	11,029	13	-	Dir. Staffing	1,741,154	2,366,513	11,042	-
Activities	11	106,651	112,584	-	-	112,584	Pat. Days	16,259	28,091	65,163	47,421
Social Services	12	132,833	156,330	-	-	156,330	Pat. Days	16,259	28,091	90,483	65,847
CNA Training	13	-	-	-	-	-	N/A	-	-	-	-
Transportation	14	-	-	-	-	-	N/A	-	-	-	-
Other	15	-	6,119	-	-	6,119	Pat. Days	16,259	28,091	3,542	2,577
Administrative	17	130,810	142,990	-	-	142,990	Net. Pat. Rev.	6,691,307	9,052,317	105,696	37,294
Directors Fees	18	-	-	-	-	-	N/A	-	-	-	-
Professional Fees	19	-	86,401	-	-	86,401	Net. Pat. Rev.	6,691,307	9,052,317	63,866	22,535
Dues and Subscriptions	20	-	65,629	-	2,590	63,039	Net. Pat. Rev.	6,691,307	9,052,317	49,187	16,442
Office and Clerical	21	222,274	544,871	-	2,111	542,760	Net. Pat. Rev.	6,691,307	9,052,317	403,309	141,562
Employee Benefits	22	-	789,230	-	-	789,230	Alloc. Salary	2,566,633	3,745,729	540,793	248,437
Inservice Training and Expense	23	-	9,721	-	-	9,721	Pat. Days	16,259	28,091	4,926	4,795
Travel and Seminar	24	-	2,207	-	-	2,207	Pat. Days	16,259	28,091	1,277	930
Other Staff Transportation	25	-	5,693	-	66	5,627	Pat. Days	16,259	28,091	3,323	2,370
Insurance	26	-	148,138	-	-	148,138	Net. Pat. Rev.	6,691,307	9,052,317	109,501	38,637
Other	27	-	51,420	-	-	51,420	Alloc. Salary	2,566,633	3,745,729	35,234	16,186
Depreciation	30	-	783,235	-	-	783,235	SQFT	46,408	93,475	388,857	394,378
Amortization	31	-	-	-	-	-	N/A	-	-	-	-
Interest	32	-	857,060	-	-	857,060	SQFT	46,408	93,475	425,509	431,551
Real Estate Taxes	33	-	-	-	-	-	N/A	-	-	-	-
Rent - Facilities and Grounds	34	-	8,927	-	-	8,927	SQFT	46,408	93,475	4,432	4,495
Rent - Equipment and Vehicles	35	-	1,713	-	-	1,713	Pat. Days	16,259	28,091	991	722
Other	36	-	-	-	-	-	N/A	-	-	-	-
Medically Necessary Transportation	38	-	-	-	-	-	N/A	-	-	-	-
Ancillary Service Centers	39	-	1,076,136	-	1,076,136	-	Direct	-	-	1,076,136	-
Barber and Beauty Shop	40	-	-	-	-	-	Direct	-	-	-	-
Coffee and Gift Shops	41	-	-	-	-	-	Direct	-	-	-	-
Provider Participation Fee	42	-	97,911	-	97,911	-	Direct	-	-	97,911	-
Other	43	698,503	-	-	-	-	Direct	-	-	-	-
		3,745,729		1,752,183	1,248,171	5,413,743				6,228,919	2,185,178

STATE OF ILLINOIS

Summary A

Facility Name & ID Number St Joseph Village of Chicago # 0046581 **Report Period Beginning:** 07/01/16 **Ending:** 06/30/17

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	(234,158)	0	0	0	0	0	0	0	0	0	0	(234,158)	1
2	Food Purchase	(104,967)	0	0	0	0	0	0	0	0	0	0	(104,967)	2
3	Housekeeping	(92,482)	0	0	0	0	0	0	0	0	0	0	(92,482)	3
4	Laundry	(19,348)	0	0	0	0	0	0	0	0	0	0	(19,348)	4
5	Heat and Other Utilities	(116,907)	0	0	0	0	0	0	0	0	0	0	(116,907)	5
6	Maintenance	(96,625)	0	9,175	0	0	0	0	0	0	0	0	(87,450)	6
7	Other (specify):*	(607)	0	1,440	0	0	0	0	0	0	0	0	833	7
8	**TOTAL General Services**	(665,094)	0	10,615	0	0	0	0	0	0	0	0	(654,479)	8
	B. Health Care and Programs													
9	Medical Director	(3,488)	0	0	0	0	0	0	0	0	0	0	(3,488)	9
10	Nursing and Medical Records	(57,314)	0	28,953	0	0	0	0	0	0	0	0	(28,361)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(47,421)	0	0	0	0	0	0	0	0	0	0	(47,421)	11
12	Social Services	(65,847)	0	0	0	0	0	0	0	0	0	0	(65,847)	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):*	(2,577)	0	6,119	0	0	0	0	0	0	0	0	3,542	15
16	**TOTAL Health Care and Programs**	(176,647)	0	35,072	0	0	0	0	0	0	0	0	(141,575)	16
	C. General Administration													
17	Administrative	(37,294)	0	(578,952)	0	0	0	0	0	0	0	0	(616,246)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(37,138)	0	33,964	0	0	0	0	0	0	0	0	(3,174)	19
20	Fees, Subscriptions & Promotions	(16,442)	0	11,789	0	0	0	0	0	0	0	0	(4,653)	20
21	Clerical & General Office Expenses	(284,659)	0	246,771	0	0	0	0	0	0	0	0	(37,888)	21
22	Employee Benefits & Payroll Taxes	0	0	(31,474)	0	0	0	0	0	0	0	0	(31,474)	22
23	Inservice Training & Education	(4,795)	0	4,370	0	0	0	0	0	0	0	0	(425)	23
24	Travel and Seminar	(930)	0	949	0	0	0	0	0	0	0	0	19	24
25	Other Admin. Staff Transportation	(2,370)	0	4,184	0	0	0	0	0	0	0	0	1,814	25
26	Insurance-Prop.Liab.Malpractice	(47,249)	0	9,055	0	0	0	0	0	0	0	0	(38,194)	26
27	Other (specify):*	(16,186)	0	51,420	0	0	0	0	0	0	0	0	35,234	27
28	**TOTAL General Administration**	(447,063)	0	(247,924)	0	0	0	0	0	0	0	0	(694,987)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(1,288,804)	0	(202,237)	0	0	0	0	0	0	0	0	(1,491,041)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number St Joseph Village of Chicago **#** 0046581 **Report Period Beginning:** 07/01/16 **Ending:** 06/30/17

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	(394,378)	0	14,568	0	0	0	0	0	0	0	0	(379,810)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(437,389)	0	0	0	0	0	0	0	0	0	0	(437,389)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	(4,495)	0	8,927	0	0	0	0	0	0	0	0	4,432	34
35	Rent-Equipment & Vehicles	(722)	0	1,117	0	0	0	0	0	0	0	0	395	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(836,984)	0	24,612	0	0	0	0	0	0	0	0	(812,372)	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	(15,751)	0	0	0	0	0	0	0	0	0	0	(15,751)	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):*	(955,155)	0	0	0	0	0	0	0	0	0	0	(955,155)	43
44	**TOTAL Special Cost Centers**	(970,906)	0	0	0	0	0	0	0	0	0	0	(970,906)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(3,096,694)	0	(177,625)	0	0	0	0	0	0	0	0	(3,274,319)	45

Facility Name & ID Number St Joseph Village of Chicago # 0046581 Report Period Beginning: 07/01/16 Ending: 06/30/17

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. [ ] YES [X] 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			$			$	$	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			$			$	$ *	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: 07/01/16 Ending: 06/30/17

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.							1
2								2
3	Board of Directors		St. Joseph Village of Chicago	Chicago, IL	Franciscan Sisters			3
4	Sister M. Francis Clare Radke		The Village at Victory Lakes	Lindenhurst, IL	of Chicago	Lemont, IL	Religious Cong.	4
5	James Stark		Addolorata Villa	Wheeling, IL	Franciscan Sisters			5
6	Judy Amiano		Franciscan Village	Lemont, IL	Chicago Serv Corp	Lemont, IL	Corp. Management	6
7	Andrew Duren		St. Anthony Home	Crown Point, IN	St. James			7
8	Raymond Catania		University Place	West Lafayette, IN	Senior Estates	Crete, IL	Ind. Living	8
9	Joseph Benson		Mount Alverna Village	Parma, OH	Marian Village	Homer Glen, IL	Ind. & Asst. Living	9
10	Andrea Ramirez-Justin				Franciscan			10
11	Guy Alton				Senior Estates	Louisville, KY	Ind. Living	11
12	Bobbie Parkhill				Franciscan Comm.			12
13	Tracy Shearer				Based Services	Michigan City, IN	Hm. Care / Hospice	13
14	Ronald Tinsley				Franciscan			14
15	Denise Bourdreau				Advisory Services	Lemont, IL	Consulting Serv.	15
16					St. Joseph			16
17					Senior Housing	Lemont, IL	Affordable Housing	17
18					St. Jude House	Crown Point, IN	Dom. Viol. Shelter	18
19					Madonna Found.	Lemont, IL	HS Foundation	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: 07/01/16 Ending: 06/30/17

VII. RELATED PARTIES (continued)

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)	
15	V	6	Maintenance - Salary	$	Franciscan Sisters of Chicago Service Corporation	100.00%	$ 6,295	$ 6,295	15
16	V	6	Maintenance - Other		Franciscan Sisters of Chicago Service Corporation	100.00%	2,880	2,880	16
17	V	7	Emp. Ben. - General Services		Franciscan Sisters of Chicago Service Corporation	100.00%	1,440	1,440	17
18	V	10	Nursing - Salary		Franciscan Sisters of Chicago Service Corporation	100.00%	26,743	26,743	18
19	V	10	Nursing - Other		Franciscan Sisters of Chicago Service Corporation	100.00%	2,210	2,210	19
20	V	15	Emp. Ben. - HC and Programs		Franciscan Sisters of Chicago Service Corporation	100.00%	6,119	6,119	20
21	V	17	Administrative - Salary		Franciscan Sisters of Chicago Service Corporation	100.00%	12,180	12,180	21
22	V	17	Administrative - Other	591,132	Franciscan Sisters of Chicago Service Corporation	100.00%		(591,132)	22
23	V	19	Professional Fees		Franciscan Sisters of Chicago Service Corporation	100.00%	33,964	33,964	23
24	V	20	Dues and Subscriptions		Franciscan Sisters of Chicago Service Corporation	100.00%	11,789	11,789	24
25	V	21	Clerical - Salary		Franciscan Sisters of Chicago Service Corporation	100.00%	212,567	212,567	25
26	V	21	Clerical - Other		Franciscan Sisters of Chicago Service Corporation	100.00%	34,204	34,204	26
27	V	22	Employee Benefits		Franciscan Sisters of Chicago Service Corporation	100.00%	(31,474)	(31,474)	27
28	V	23	Inservice Expense		Franciscan Sisters of Chicago Service Corporation	100.00%	4,370	4,370	28
29	V	24	Seminar and Travel		Franciscan Sisters of Chicago Service Corporation	100.00%	949	949	29
30	V	25	Other Staff Admin. Transp.		Franciscan Sisters of Chicago Service Corporation	100.00%	4,184	4,184	30
31	V	26	Insurance		Franciscan Sisters of Chicago Service Corporation	100.00%	9,055	9,055	31
32	V	27	Emp. Ben. - General Admin.		Franciscan Sisters of Chicago Service Corporation	100.00%	51,420	51,420	32
33	V	30	Depreciation		Franciscan Sisters of Chicago Service Corporation	100.00%	14,568	14,568	33
34	V	32	Interest		Franciscan Sisters of Chicago Service Corporation	100.00%	0		34
35	V	33	Real Estate Taxes		Franciscan Sisters of Chicago Service Corporation	100.00%	0		35
36	V	34	Rent - Building		Franciscan Sisters of Chicago Service Corporation	100.00%	8,927	8,927	36
37	V	35	Rent - Equipment		Franciscan Sisters of Chicago Service Corporation	100.00%	1,117	1,117	37
38	V								38
39	Total			$ 591,132			$ 413,507	$ * (177,625)	39

* 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: 07/01/16 Ending: 06/30/17

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	2.44	6.09%	Alloc. Salary	$ 12,180	17 - 07	1
2								Alloc. Ben.	2,787	27 - 07	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 14,967		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
07/01/16 - 06/30/17

Page 7 Supplemental Schedule

				Total Compensation			Alloc. Compensation	
Desciption	**Alloc. Hours**	**Total Hours**	**Alloc. Percentage**	**Salary**	**Emp. Benefits**		**Salary**	**Emp. Benefits**
Owners / Director Compensation - Judy Amiano (President and CEO)								
Addolorata Villa	5.10	40	12.74%	200,000	45,758		25,487	5,831
Franciscan Village	6.41	40	16.04%	200,000	45,758		32,074	7,338
St. Joseph Village	2.44	40	6.09%	200,000	45,758		12,180	2,787
Village at Victory Lakes	5.41	40	13.53%	200,000	45,758		27,064	6,192
Other	20.64	40	51.60%	200,000	45,758		103,194	23,610
							-	-
							-	-
							-	-
							-	-
							-	-
							-	-
							-	-
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							-	-
							-	-
							-	-
							-	-
							-	-
							-	-
							-	-
Total	40		100.00%				200,000	45,758

Facility Name & ID Number St Joseph Village of Chicago # 0046581 Report Period Beginning: 07/01/16 Ending: 06/30/17

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 [X]

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number St Joseph Village of Chicago # 0046581 Report Period Beginning: 07/01/16 Ending: 06/30/17

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 Service Corp.
Street Address: 11500 Theresa Dr.
City / State / Zip Code: Lemont, IL 60439
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	6	Maintenance - Salary	Management Fees	9,706,344	13	$ 103,364	$ 103,364	591,132	$ 6,295	1
2	6	Maintenance - Other	Management Fees	9,706,344	13	47,290		591,132	2,880	2
3	7	Emp. Ben. - General Services	Management Fees	9,706,344	13	23,649		591,132	1,440	3
4	10	Nursing - Salary	Management Fees	9,706,344	13	439,115	439,115	591,132	26,743	4
5	10	Nursing - Other	Management Fees	9,706,344	13	36,289		591,132	2,210	5
6	15	Emp. Ben. - HC and Programs	Management Fees	9,706,344	13	100,466		591,132	6,119	6
7	17	Administrative - Salary	Management Fees	9,706,344	13	200,000	200,000	591,132	12,180	7
8	19	Professional Fees	Management Fees	9,706,344	13	557,689		591,132	33,964	8
9	20	Dues and Subscriptions	Management Fees	9,706,344	13	193,579		591,132	11,789	9
10	21	Clerical - Salary	Management Fees	9,706,344	13	3,490,336	3,490,336	591,132	212,567	10
11	21	Clerical - Other	Management Fees	9,706,344	13	561,623		591,132	34,204	11
12	22	Employee Benefits	Hlth. Ins. Premiums	6,876,811	10	(572,318)		378,184	(31,474)	12
13	23	Inservice Expense	Management Fees	9,706,344	13	71,747		591,132	4,370	13
14	24	Seminar and Travel	Management Fees	9,706,344	13	15,578		591,132	949	14
15	25	Other Staff Admin. Trans.	Management Fees	9,706,344	13	68,701		591,132	4,184	15
16	26	Insurance	Management Fees	9,706,344	13	148,675		591,132	9,055	16
17	27	Emp. Ben. - General Admin.	Management Fees	9,706,344	13	844,320		591,132	51,420	17
18	30	Depreciation	Management Fees	9,706,344	13	239,212		591,132	14,568	18
19	32	Interest	Management Fees	9,706,344	13			591,132		19
20	33	Real Estate Taxes	Management Fees	9,706,344	13			591,132		20
21	34	Rent - Building	Management Fees	9,706,344	13	146,578		591,132	8,927	21
22	35	Rent - Equipment	Management Fees	9,706,344	13	18,339		591,132	1,117	22
23										23
24										24
25	TOTALS					$ 6,734,232	$ 4,232,815		$ 413,507	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number St Joseph Village of Chicago # 0046581 Report Period Beginning: 07/01/16 Ending: 06/30/17

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	03/13/13	$ 12,724,936	$ 9,601,483	05/15/47	4.860%	$ 440,702	1
2	Huntington Bank		X	Facility Acquisition	Varies	03/13/13	3,060,619		06/28/17	Variable	105,999	2
3	Amalgamated Bank		X	Facility Acquisition	Varies	06/28/17	3,924,698	3,924,698	05/01/47	4.860%	135,924	3
4	Huntington Bank		X	Facility Acquisition	Varies	06/28/17	3,648,758	3,648,758	05/01/47	Variable	126,367	4
5	Wintrust Bank		X	Facility Acquisition	Varies	06/28/17	1,556,492	1,556,492	05/01/47	Variable	53,906	5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 24,915,503	$ 18,731,431			$ 862,898	9
	B. Non-Facility Related*											
10	Interest Income		X								(5,838)	10
11												11
12	Alloc. - Non-Allowable AL										(431,551)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (437,389)	14
15	TOTALS (line 9+line14)						$ 24,915,503	$ 18,731,431			$ 425,509	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:** 07/01/16 **Ending:** 06/30/17

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 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 2017 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:			
	2012		8
	2013		9
	2014		10
	2015		11
	2016		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 2016	$	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

2016 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 Christopher S. Joos

TELEPHONE (614) 222 - 9040 FAX #: (248) 233 - 8811

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

Enter the tax index number and real estate tax assessed for 2016 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 2016.

	(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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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: 07/01/16 Ending: 06/30/17

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 46,408 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 2

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. [X] (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: 07/01/16 Ending: 06/30/17

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	Various			2013	10,229						14
15	Nurse Workstations - 3rd Floor (TC = $5,875)			2014	5,875						15
16	Entrance Sign and Lighting - Main Entrance (TC = $14,555)			2014	7,226						16
17	Gazebo (TC = $8,430)			2015	4,185						17
18	Boiler - Boiler Tubes and Head Gaskets (TC = $3,290)			2015	1,589						18
19	Sidewalk and Landscapting (TC = $8,100)			2015	4,021						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

*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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number St Joseph Village of Chicago # 0046581 Report Period Beginning: 07/01/16 Ending: 06/30/17

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: 07/01/16 Ending: 06/30/17

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 Fiscal Year Additions: 2016 - 2017								3
4									4
5	Landscaping - Gazebo (TC = $6,770)	2016	3,361						5
6	Boiler Room - Boiler (TC = $48,877)	2017	24,266						6
7	Boiler Room - Ejector Pump (TC = $3,782)	2017	1,878						7
8	Security System (TC = $5,045)	2017	2,505						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	Depreciation			388,857		388,857		5,506,346	32
33									33
34	TOTAL (lines 1 thru 33)		$ 9,975,745	$ 388,857		$ 388,857	$	$ 5,506,346	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
07/01/16 - 06/30/17

Page 12D - CY Leasehold Improvement Additions

Desciption	Acquisiton Date	Cost	Class	Method	Capitalized		Expensed	
					Nursing Home	Other	Nursing Home	Other
Landscaping - Gazebo (TC = $6,770)	2016	6,770	LIMP	Indirect	3,361	3,409	-	-
Boiler Room - Boiler (TC = $48,877)	2017	48,877	LIMP	Indirect	24,266	24,611	-	-
Ejector Pump (TC = $3,782)	2017	3,782	LIMP	Indirect	1,878	1,904	-	-
Security System (TC = $5,045)	2017	5,045	LIMP	Indirect	2,505	2,540	-	-
Roof Inspection (TC = $965)	2016	965	LIMP	Expense	-	-	479	486
Fire Alarm System (TC = $2,150)	2017	2,150	LIMP	Expense	-	-	1,067	1,083
Signage (TC = $263)	2017	263	LIMP	Expense	-	-	131	132
Non-Care	2017	133,724	LIMP	Direct - OTH	-	133,724	-	-
		201,576			32,010	166,188	1,677	1,701

Facility Name & ID Number St Joseph Village of Chicago # 0046581 Report Period Beginning: 07/01/16 Ending: 06/30/17

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	31,104						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 725,900	$	$	$		$	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)	$ 10,899,725	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 388,857	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 388,857	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)	$ 5,506,346	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	$ 10,951,368	$	$	86
87	Non-Care Assets - CY LIMP Add.	166,188			87
88	Non-Care Assets - CY EQIP Add.	26,959			88
89					89
90	Depreciaton		394,378	5,584,536	90
91	TOTALS	$ 11,144,515	$ 394,378	$ 5,584,536	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.

SEE ACCOUNTANTS' PREPARATION REPORT

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

St Joseph Village of Chicago
Medicaid Cost Report
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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**
Oxygen Equipment (TC = $6,207)	2016	6,207	EQIP	Direct - NH	6,207	-	-	-
Wireless Syste Upgrade (TC = $5,579)	2017	5,579	EQIP	Indirect	2,770	2,809	-	-
Bed Panels & Mattresses (TC = $22,127)	2016	22,127	EQIP	Direct - NH	22,127	-	-	-
Wheelchairs (TC = $1,636)	2016	1,636	EQIP	Direct EXP - NH	-	-	1,636	-
Non-Care (TC = $6,968)	2016	6,968	EQIP	Direct - OTH	-	6,968	-	-
Non-Care (TC = $17,182)	2017	17,182	EQIP	Direct - OTH	-	17,182	-	-
		59,699			31,104	26,959	1,636	-

Facility Name & ID Number St Joseph Village of Chicago # 0046581 Report Period Beginning: 07/01/16 Ending: 06/30/17

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 ☐ 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				4,432			5
6								6
7	TOTAL				$ 4,432 **			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.	/2018	$
13.	/2019	$
14.	/2020	$

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: $ 991 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.

SEE ACCOUNTANTS' PREPARATION REPORT

St Joseph Village of Chicago
Medicaid Cost Report
07/01/16 - 06/30/17

Page 14 Supplemental Schedule

Desciption	Amount	Total
Building Rental		
Franciscan Sisters of Chicago Serv Corp		-
Alloc. - Building Rent	8,927	8,927
		-
Alloc. - Non-Allowable AL	(4,495)	(4,495)
		-
		-
		-
		-
		-
		-
		-
		-
		-
Total	4,432	4,432
Equipment Rental		
Franciscan Sisters of Chicago Serv Corp		-
Alloc. - Equipment Rent	1,117	1,117
		-
Postage Machine	596	596
		-
Alloc. - Non-Allowable AL	(722)	(722)
		-
		-
		-
		-
		-
		-
		-
Total	991	991

Facility Name & ID Number St Joseph Village of Chicago # 0046581 Report Period Beginning: 07/01/16 Ending: 06/30/17

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	$		$ 228,034	$		$ 228,034	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			60,016			60,016	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			331,116			331,116	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				239,915		239,915	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): See Supplemental	39 - 02					101,617		101,617	12
13	Other (specify): See Supplemental	39 - 03				115,438			115,438	13
14	TOTAL			$		$ 734,604	$ 341,532		$ 1,076,136	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

St Joseph Village of Chicago
Medicaid Cost Report
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Page 16 Supplemental Schedule

Description	Salaries	Supplies	Other	Total
Medical Supplies		94,221		94,221
Oxygen and Supplies		7,396		7,396
Medical Equipment Rental			56,613	56,613
Laboratory			8,055	8,055
Radiology			6,050	6,050
Ambulance			25,956	25,956
Other			18,764	18,764
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
Total	-	101,617	115,438	217,055

Facility Name & ID Number St Joseph Village of Chicago # 0046581 Report Period Beginning: 07/01/16 Ending: 06/30/17

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/17 (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	$ 204	$	1
2	Cash-Patient Deposits	3,697		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 152,690)	819,636		3
4	Supply Inventory (priced at Cost / FIFO)	31,939		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	58,596		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Supplemental Schedule	2,265		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 916,337	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	1,355,189		13
14	Buildings, at Historical Cost	15,183,540		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	5,363,599		16
17	Accumulated Depreciation (book methods)	(11,090,882)		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			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 10,811,446	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 11,727,783	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 305,741	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	3,697		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	334,542		30
31	Accrued Taxes Payable (excluding real estate taxes)	5,070		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	151,988		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 801,038	$	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)**	$ 801,038	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 10,926,745	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 11,727,783	$	48

SEE ACCOUNTANTS' PREPARATION REPORT

***(See instructions.)**

St Joseph Village of Chicago
Medicaid Cost Report
07/01/16 - 06/30/17

Page 17 Supplemental Schedule

Description	Operating	Building	Total
Line 9 - Other Current Assets			
Other Current Receivables	2,265		2,265
			-
			-
			-
			-
Sub-Total	2,265	-	2,265
Line 23 - Long Term Assets			
			-
			-
			-
			-
			-
Sub-Total	-	-	-
Line 36 - Other Current Liability			
Refundable Deposits	81,623		81,623
Unrefundable Deposits (Net of Amort.)	57,123		57,123
Reservation Deposits	13,242		13,242
			-
			-
Sub-Total	151,988	-	151,988
Line 43 - Long term Liabilities			
			-
			-
			-
			-
			-
Sub-Total	-	-	-

Facility Name & ID Number St Joseph Village of Chicago # 0046581 Report Period Beginning: 07/01/16 Ending: 06/30/17

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 11,429,291	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 11,429,291	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(505,069)	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)**	$ (505,069)	17
	B. Transfers (Itemize):		
18	**Temporarily Restricted Net Assets Released**	2,523	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 2,523	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 10,926,745	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: 07/01/16 Ending: 06/30/17

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	$ 9,052,317	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 9,052,317	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	120,009	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 120,009	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	19,067	13
14	Non-Patient Meals	12,404	14
15	Telephone, Television and Radio	5,133	15
16	Rental of Facility Space	75	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	6,967	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 43,646	23
	D. Non-Operating Revenue		
24	Contributions	8,162	24
25	Interest and Other Investment Income***	5,838	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 14,000	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	16,634	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 16,634	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,246,606	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,435,673	31
32	Health Care	2,278,352	32
33	General Administration	2,260,536	33
	B. Capital Expense		
34	Ownership	1,632,161	34
	C. Ancillary Expense		
35	Special Cost Centers	2,047,042	35
36	Provider Participation Fee	97,911	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,751,675	40
41	**Income before Income Taxes (line 30 minus line 40)****	(505,069)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (505,069)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 457,895	44
45	Private Pay - Net Inpatient Revenue	2,819,651	45
46	Medicare - Net Inpatient Revenue	2,705,594	46
47	Other-(specify) Insurance - Net Inpatient Revenue	708,167	47
48	Other-(specify) Private Pay - Assisted and Independent Living	2,361,010	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 9,052,317	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

Page 19 Supplemental Schedule

Description	Amount	Total
Transportation Revenue	7,731	7,731
Insurance Settlement	8,612	8,612
Miscellaneous Revenue	291	291
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
Total	16,634	16,634

Facility Name & ID Number St Joseph Village of Chicago # 0046581 Report Period Beginning: 07/01/16 Ending: 06/30/17

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	630	1,122	$ 56,236	$ 50.12	1
2	Assistant Director of Nursing					2
3	Registered Nurses	26,598	28,839	1,015,745	35.22	3
4	Licensed Practical Nurses	2,864	3,355	94,348	28.12	4
5	CNAs & Orderlies	40,213	44,582	622,675	13.97	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	292	317	11,029	34.79	8
9	Activity Director	1,952	2,080	56,549	27.19	9
10	Activity Assistants	3,990	2,387	50,102	20.99	10
11	Social Service Workers	2,005	2,085	63,089	30.26	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	5,124	5,537	93,107	16.82	14
15	Cook Helpers/Assistants	12,400	13,267	152,816	11.52	15
16	Dishwashers					16
17	Maintenance Workers	3,458	3,722	79,336	21.32	17
18	Housekeepers	10,461	11,635	159,763	13.73	18
19	Laundry	2,722	2,837	34,546	12.18	19
20	Administrator	2,016	2,080	130,810	62.89	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,212	11,563	222,274	19.22	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	678	694	10,369	14.94	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	45,361	48,263	892,935	18.50	33
34	TOTAL (lines 1 - 33)	171,976	184,365	$ 3,745,729 *	$ 20.32	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		13,200	09 - 03	36
37	Medical Records Consultant		1,200	10 - 03	37
38	Nurse Consultant				38
39	Pharmacist Consultant		3,831	10 - 03	39
40	Physical Therapy Consultant		13	10A - 03	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant		393	11 - 03	44
45	Social Service Consultant				45
46	Other(specify) See Supplemental		276,455		46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 295,092		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
07/01/16 - 06/30/17

Page 20 Supplemental Schedule

Description	CC Reference	Hours Worked	Hours Paid	Salary	Average Rate	Hours Paid	Contracted Cost
Nursing Home Employees							
Other Nursing Admin	10	5,137	5,629	124,688	22.15		
Pastoral Care	12	1,762	2,046	69,744	34.09		
Assisted Living	43	36,344	38,430	625,359	16.27		
Marketing	43	2,118	2,158	73,144	33.89		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
Total		45,361	48,263	892,935	18.50		
Contracted Services							
Dietary Management	01						52,139
Dietary Contracted Services	01						203,941
Priest	12						18,550
Organists	12						1,825
Total						-	276,455

Facility Name & ID Number St Joseph Village of Chicago # 0046581 Report Period Beginning: 07/01/16 Ending: 06/30/17

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Brian Celerio	Executive Dir	0	$ 130,810
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 130,810

B. Administrative - Other

Description	Amount
Franciscan Sisters of Chicago Service Corp.	$ 591,132
TOTAL (agree to Schedule V, line 17, col. 3)	$ 591,132
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Plante & Moran, PLLC	Accounting	$ 13,675
Probusiness / Ultipro	Payroll Processing	15,077
Ability Network	Data Processing	5,747
FMLA Source	Data Processing	800
PointRight	Data Processing	4,635
OnShift	Data Processing	2,824
Joint Commission	Accredidation	1,263
Achieve Accredidation	Accredidation	8,210
CT Corporation	Other	113
Employeeware LLC	Other	93
Non-Allowable	Collections	14,603
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 67,040

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 12,455
Unemployment Compensation Insurance	(16,234)
FICA Taxes	282,397
Employee Health Insurance	314,740
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Dental Insurance	10,736
Vision Insurance	1,345
Disability Insurance	9,836
Life Insurance	6,720
Retirement Benefits	81,378
Other Employee Benefits	117,331
Alloc. - FSCSC (See Page 6 Allocations)	(31,474)
TOTAL (agree to Schedule V, line 22, col.8)	$ 789,230

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	26,395
Health Care Worker Background Check	6,480
(Indicate # of checks performed)	
Patient Background Checks	
Dues and Subscriptions	16,360
Licenses	3,580
Inspection Fees	1,025
Alloc. - FSCSC (See Page 6 Allocations)	11,789
Alloc. - Non-Allowable AL	(16,442)
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 49,187

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,258
Alloc. - FSCSC (See Page 6 Allocations)	949
Alloc. - Non-Allowable AL	(930)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,277

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number St Joseph Village of Chicago # 0046581 Report Period Beginning: 07/01/16 Ending: 06/30/17

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. **Leading Age - $9,192**

(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. $ **19,106** 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. $ **97,911**
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. $ **12,404**

(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. **N/A**
Attach invoices and a summary of services for all architect and appraisal fees