		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.

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

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			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Denise A. Leonard **Telephone Number:** (216) 274-6514
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 07/01/19 to 06/30/20 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) Denise A. Leonard, CPA, Partner, Health and Human Services
(Firm Name & Address) Plante & Moran, PLLC, 1111 Superior Ave #1250, Cleveland, OH 44114
(Telephone) (216) 274-6514 Fax # (248) 233-7349

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

Facility Name & ID Number St Joseph Village of Chicago # 0046581 Report Period Beginning: 07/01/19 Ending: 06/30/20

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 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	3,841	5,906	6,965	16,712	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	3,841	5,906	6,965	16,712	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.56%

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 5,300

Medicare Intermediary National Government Services, Inc.

IV. ACCOUNTING BASIS

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

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

Tax Year: 06/30/20 Fiscal Year: 06/30/20

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

Facility Name & ID Number St Joseph Village of Chicago # 0046581 Report Period Beginning: 07/01/19 Ending: 06/30/20

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	117,912	34,880	545,824	698,616		698,616	(259,927)	438,689			1
2	Food Purchase		205,068		205,068		205,068	(79,099)	125,969			2
3	Housekeeping	155,329	29,226		184,555		184,555	(92,928)	91,627			3
4	Laundry	38,775	15,804		54,579		54,579	(20,307)	34,272			4
5	Heat and Other Utilities			215,224	215,224		215,224	(115,778)	99,446			5
6	Maintenance	88,842	27,586	98,950	215,378		215,378	(97,687)	117,691			6
7	Other (specify):* See Supplemental			25,783	25,783		25,783	(5,238)	20,545			7
8	**TOTAL General Services**	400,858	312,564	885,781	1,599,203		1,599,203	(670,964)	928,239			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000	(4,630)	13,370			9
10	Nursing and Medical Records	1,856,375	128,603	242,086	2,227,064		2,227,064	(75,132)	2,151,932			10
10a	Therapy			626,224	626,224		626,224		626,224			10a
11	Activities	38,628		4,002	42,630		42,630	(16,204)	26,426			11
12	Social Services	140,561		15,550	156,111		156,111	(58,083)	98,028			12
13	CNA Training		133	3,200	3,333		3,333	(857)	2,476			13
14	Program Transportation			934	934		934	(530)	404			14
15	Other (specify):* See Supplemental							6,711	6,711			15
16	**TOTAL Health Care and Programs**	2,035,564	128,736	909,996	3,074,296		3,074,296	(148,725)	2,925,571			16
	C. General Administration											
17	Administrative	143,019		645,528	788,547		788,547	(615,664)	172,883			17
18	Directors Fees											18
19	Professional Services			66,493	66,493		66,493	(2,074)	64,419			19
20	Dues, Fees, Subscriptions & Promotions			32,739	32,739		32,739	(4,857)	27,882			20
21	Clerical & General Office Expenses	625,558	26,976	360,067	1,012,601		1,012,601	(207,169)	805,432			21
22	Employee Benefits & Payroll Taxes			885,943	885,943		885,943		885,943			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,420	1,420		1,420	2,724	4,144			24
25	Other Admin. Staff Transportation			4,674	4,674		4,674	(1,739)	2,935			25
26	Insurance-Prop.Liab.Malpractice			238,957	238,957		238,957	(51,981)	186,976			26
27	Other (specify):* See Supplemental	91,298	630	101,338	193,266		193,266	(130,154)	63,112			27
28	**TOTAL General Administration**	859,875	27,606	2,337,159	3,224,640		3,224,640	(1,010,914)	2,213,726			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,296,297	468,906	4,132,936	7,898,139		7,898,139	(1,830,603)	6,067,536			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

St. Joseph Village of Chicago
Medicaid Cost Report
07/01/19 - 06/30/20

Page 3 Supplemental Schedule

Description	Salaries	Supplies	Other	Adjustments	Total
Line 7 - Other General Services					
Franciscan Sisters of Chicago Serv Corp					-
Alloc. - Employee Benefits				3,461	3,461
					-
Alloc. - Non-Allowable AL / IL				(8,699)	(8,699)
					-
Trash and Refuse Removal			9,742		9,742
Security Services			16,041		16,041
Sub-Total	-	-	25,783	(5,238)	20,545
Line 15 - Other Health Care Services					
Franciscan Sisters of Chicago Serv Corp					-
Alloc. - Employee Benefits				9,553	9,553
					-
Alloc. - Non-Allowable AL / IL				(2,842)	(2,842)
					-
					-
					-
Sub-Total	-	-	-	6,711	6,711
Line 27 - Other General Administration					
Franciscan Sisters of Chicago Serv Corp					-
Alloc. - Employee Benefits				86,961	86,961
					-
Alloc. - Non-Allowable AL / IL				(26,723)	(26,723)
					-
Promotional Advertising/Marketing	91,298	630	97,857	(189,785)	-
Other Administrative			2,874		2,874
Contributions and Donations			607	(607)	-
Sub-Total	91,298	630	101,338	(130,154)	63,112

Facility Name & ID Number St Joseph Village of Chicago #0046581 Report Period Beginning: 07/01/19 Ending: 06/30/20

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			798,465	798,465		798,465	(393,129)	405,336			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			739,735	739,735		739,735	(372,484)	367,251			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds							59	59			34
35	Rent-Equipment & Vehicles			26,804	26,804		26,804	(8,960)	17,844			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,565,004	1,565,004		1,565,004	(774,514)	790,490			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		122,713	341,834	464,547		464,547		464,547			39
40	Barber and Beauty Shops			5,913	5,913		5,913	(5,913)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			99,900	99,900		99,900		99,900			42
43	Other (specify):* See Supplemental	613,892	11,015	104,696	729,603		729,603	(729,603)				43
44	**TOTAL Special Cost Centers**	613,892	133,728	552,343	1,299,963		1,299,963	(735,516)	564,447			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,910,189	602,634	6,250,283	10,763,106		10,763,106	(3,340,633)	7,422,473			45

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

St. Joseph Village of Chicago
Medicaid Cost Report
07/01/19 - 06/30/20

Page 4 Supplemental Schedule

Description	Salaries	Supplies	Other	Adjustments	Total
Line 36 - Other Capital Costs					
					-
					-
					-
					-
					-
					-
					-
Sub-Total	-	-	-	-	-
Line 43 - Other Special Cost Centers					
Other Long Term Care (AL)	613,892	11,015	104,696	(729,603)	-
					-
					-
					-
					-
					-
					-
Sub-Total	613,892	11,015	104,696	(729,603)	-

Facility Name & ID Number St Joseph Village of Chicago # 0046581 Report Period Beginning: 07/01/19 Ending: 06/30/20

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 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(4,462)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(17)	32		10
11	Discounts, Allowances, Rebates & Refunds	6,244	21		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	(36)	21		18
19	Entertainment				19
20	Contributions	(607)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(319,481)	21		24
25	Fund Raising, Advertising and Promotional	(189,785)	27		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	(2,861,551)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (3,369,695)		$	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)	29,062	VII-B	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 29,062		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (3,340,633)		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

St Joseph Village of Chicago

ID# 0046581

Report Period Beginning: 07/01/19

Ending: 06/30/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Independent Living	$ 0	43	1
2	Non-Allowable Benefits (Marketing & ILU)	0	22	2
3	Cable	(14,919)	5	3
4	Assisted Living	(729,603)	43	4
5	Beauty Shop	(5,913)	40	5
6	Other Non Reimbursable- Other	0	43	6
7	Other Income- Activities	(546)	11	7
8	Other Income- Administrative	(2,036)	21	8
9	Communications	(279)	21	9
10	Other Income-Transportation	(290)	14	10
11	Other Income-Laundry	0	4	11
12	Misc. Revenue	(184)	21	12
13	Personal Supplies	(5,753)	10	13
14	Additional R&M	3,941	6	14
15		0		15
16	Page 5 SUPP - Assisted Living Allocations	0		16
17	Dietary	(259,927)	01	17
18	Food	(74,637)	02	18
19	Housekeeping	(92,928)	03	19
20	Laundry	(20,307)	04	20
21	Utilities	(100,859)	05	21
22	Maintenance	(119,362)	06	22
23	Other	(8,699)	07	23
24	Medical Director	(4,630)	09	24
25	Nursing and Medical Records	(112,943)	10	25
26	Therapy	0	10A	26
27	Activities	(15,658)	11	27
28	Social Services	(58,083)	12	28
29	CNA Training	(857)	13	29
30	**Transportation**	(240)	14	30
31	Other	(2,842)	15	31
32	Administrative	(56,211)	17	32
33	Director Fees	0	18	33
34	Professional Fees	(20,945)	19	34
35	Dues and Subscriptions	(9,065)	20	35
36	Clerical	(261,876)	21	36
37	Employee Benefits (Not ADJ - Rate Calculation)	0	22	37
38	Inservice Training	0	23	38
39	Seminar Travel	(2,455)	24	39
40	Other Staff Admin Transportation	(1,739)	25	40
41	Insurance	(60,793)	26	41
42	Other	(26,723)	27	42
43	Depreciation	(411,092)	30	43
44	Amortization	0	31	44
45	Interest	(372,467)	32	45
46	Real Estate Taxes	0	33	46
47	Rent - Building	(59)	34	47
48	Rent - Equipment	(10,572)	35	48
49	**Total**	(2,861,551)		49

St. Joseph Village of Chicago
Medicaid Cost Report
07/01/19 - 06/30/20

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	117,912	698,616			698,616	Meals Served	50,136	79,842	438,689	259,927
Food	2	-	200,606			200,606	Meals Served	50,136	79,842	125,969	74,637
Housekeeping	3	155,329	184,555			184,555	SQFT	46,408	93,475	91,627	92,928
Laundry	4	38,775	54,579			54,579	Pat. Days	16,712	26,614	34,272	20,307
Heat and Other Utilities	5	-	200,305			200,305	SQFT	46,408	93,475	99,446	100,859
Maintenance	6	88,842	237,053			237,053	SQFT	46,408	93,475	117,691	119,362
Other	7	-	29,244			29,244	Alloc. Salary	2,747,037	3,910,189	20,545	8,699
Medical Director	9	-	18,000			18,000	Dir. Staffing	1,772,897	2,386,789	13,370	4,630
Nursing and Medical Records	10	1,856,375	2,264,875	1,772,897	52,860	439,118	Dir. Staffing	1,772,897	2,386,789	2,151,932	112,943
Therapy	10a	-	626,224			626,224	Direct	-	-	626,224	-
Activities	11	38,628	42,084			42,084	Pat. Days	16,712	26,614	26,426	15,658
Social Services	12	140,561	156,111			156,111	Pat. Days	16,712	26,614	98,028	58,083
CNA Training	13	-	3,333			3,333	Dir. Staffing	1,772,897	2,386,789	2,476	857
Transportation	14	-	644			644	Pat. Days	16,712	26,614	404	240
Other	15	-	9,553			9,553	Alloc. Salary	2,747,037	3,910,189	6,711	2,842
Administrative	17	143,019	229,094			229,094	Net. Pat. Rev.	6,630,425	8,786,219	172,883	56,211
Directors Fees	18	-	-			-	N/A	-	-	-	-
Professional Fees	19	-	85,364			85,364	Net. Pat. Rev.	6,630,425	8,786,219	64,419	20,945
Dues and Subscriptions	20	-	36,947			36,947	Net. Pat. Rev.	6,630,425	8,786,219	27,882	9,065
Office and Clerical	21	625,558	1,067,308			1,067,308	Net. Pat. Rev.	6,630,425	8,786,219	805,432	261,876
Employee Benefits	22	-	885,943			885,943	Not Adj - Rate Calc			885,943	-
Inservice Training and Expense	23	-	-			-	Pat. Days	16,712	26,614	-	-
Travel and Seminar	24	-	6,599			6,599	Pat. Days	16,712	26,614	4,144	2,455
Other Staff Transportation	25	-	4,674			4,674	Pat. Days	16,712	26,614	2,935	1,739
Insurance	26	-	247,769			247,769	Net. Pat. Rev.	6,630,425	8,786,219	186,976	60,793
Other	27	91,298	89,835			89,835	Alloc. Salary	2,747,037	3,910,189	63,112	26,723
Depreciation	30	-	816,428			816,428	SQFT	46,408	93,475	405,336	411,092
Amortization	31	-	-			-	N/A	-	-	-	-
Interest	32	-	739,718			739,718	SQFT	46,408	93,475	367,251	372,467
Real Estate Taxes	33	-	-			-	N/A	-	-	-	-
Rent - Facilities and Grounds	34	-	118			118	SQFT	46,408	93,475	59	59
Rent - Equipment and Vehicles	35	-	28,416			28,416	Pat. Days	16,712	26,614	17,844	10,572
Other	36	-	-			-	N/A	-	-	-	-
Medically Necessary Transportation	38	-	-			-	N/A	-	-	-	-
Ancillary Service Centers	39	-	464,547			464,547	Direct	-	-	464,547	-
Barber and Beauty Shop	40	-	-			-	Direct	-	-	-	-
Coffee and Gift Shops	41	-	-			-	Direct	-	-	-	-
Provider Participation Fee	42	-	99,900			99,900	Direct	-	-	99,900	-
Other	43	613,892	-			-	Direct	-	-	-	-
		3,910,189	9,528,442	1,772,897	52,860	7,702,685				7,422,473	2,105,969

STATE OF ILLINOIS

Summary A

Facility Name & ID Number St Joseph Village of Chicago **#** 0046581 **Report Period Beginning:** 07/01/19 **Ending:** 06/30/20

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	(259,927)	0	0	0	0	0	0	0	0	0	0	(259,927)	1
2	Food Purchase	(79,099)	0	0	0	0	0	0	0	0	0	0	(79,099)	2
3	Housekeeping	(92,928)	0	0	0	0	0	0	0	0	0	0	(92,928)	3
4	Laundry	(20,307)	0	0	0	0	0	0	0	0	0	0	(20,307)	4
5	Heat and Other Utilities	(115,778)	0	0	0	0	0	0	0	0	0	0	(115,778)	5
6	Maintenance	(115,421)	0	17,734	0	0	0	0	0	0	0	0	(97,687)	6
7	Other (specify):*	(8,699)	0	3,461	0	0	0	0	0	0	0	0	(5,238)	7
8	**TOTAL General Services**	(692,159)	0	21,195	0	0	0	0	0	0	0	0	(670,964)	8
	B. Health Care and Programs													
9	Medical Director	(4,630)	0	0	0	0	0	0	0	0	0	0	(4,630)	9
10	Nursing and Medical Records	(118,696)	0	43,564	0	0	0	0	0	0	0	0	(75,132)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(16,204)	0	0	0	0	0	0	0	0	0	0	(16,204)	11
12	Social Services	(58,083)	0	0	0	0	0	0	0	0	0	0	(58,083)	12
13	CNA Training	(857)	0	0	0	0	0	0	0	0	0	0	(857)	13
14	Program Transportation	(530)	0	0	0	0	0	0	0	0	0	0	(530)	14
15	Other (specify):*	(2,842)	0	9,553	0	0	0	0	0	0	0	0	6,711	15
16	**TOTAL Health Care and Programs**	(201,842)	0	53,117	0	0	0	0	0	0	0	0	(148,725)	16
	C. General Administration													
17	Administrative	(56,211)	0	(559,453)	0	0	0	0	0	0	0	0	(615,664)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(20,945)	0	18,871	0	0	0	0	0	0	0	0	(2,074)	19
20	Fees, Subscriptions & Promotions	(9,065)	0	4,208	0	0	0	0	0	0	0	0	(4,857)	20
21	Clerical & General Office Expenses	(577,648)	0	370,479	0	0	0	0	0	0	0	0	(207,169)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(2,455)	0	5,179	0	0	0	0	0	0	0	0	2,724	24
25	Other Admin. Staff Transportation	(1,739)	0	0	0	0	0	0	0	0	0	0	(1,739)	25
26	Insurance-Prop.Liab.Malpractice	(60,793)	0	8,812	0	0	0	0	0	0	0	0	(51,981)	26
27	Other (specify):*	(217,115)	0	86,961	0	0	0	0	0	0	0	0	(130,154)	27
28	**TOTAL General Administration**	(945,971)	0	(64,943)	0	0	0	0	0	0	0	0	(1,010,914)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(1,839,972)	0	9,369	0	0	0	0	0	0	0	0	(1,830,603)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number St Joseph Village of Chicago # 0046581 **Report Period Beginning:** 07/01/19 **Ending:** 06/30/20

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	(411,092)	0	17,963	0	0	0	0	0	0	0	0	(393,129)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(372,484)	0	0	0	0	0	0	0	0	0	0	(372,484)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	(59)	0	118	0	0	0	0	0	0	0	0	59	34
35	Rent-Equipment & Vehicles	(10,572)	0	1,612	0	0	0	0	0	0	0	0	(8,960)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(794,207)	0	19,693	0	0	0	0	0	0	0	0	(774,514)	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	(5,913)	0	0	0	0	0	0	0	0	0	0	(5,913)	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):*	(729,603)	0	0	0	0	0	0	0	0	0	0	(729,603)	43
44	**TOTAL Special Cost Centers**	(735,516)	0	0	0	0	0	0	0	0	0	0	(735,516)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(3,369,695)	0	29,062	0	0	0	0	0	0	0	0	(3,340,633)	45

Facility Name & ID Number St Joseph Village of Chicago # 0046581 Report Period Beginning: 07/01/19 Ending: 06/30/20

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.**

Facility Name & ID Number St Joseph Village of Chicago # 0046581 Report Period Beginning: 07/01/19 Ending: 06/30/20

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	$	Francsicsan Sisters of Chicago Service Corporation	100.00%	$ 14,991	$ 14,991	15
16	V	6	Maintenance - Other		Francsicsan Sisters of Chicago Service Corporation	100.00%	2,743	2,743	16
17	V	7	Emp. Ben. - Gen. Services		Francsicsan Sisters of Chicago Service Corporation	100.00%	3,461	3,461	17
18	V	10	Nursing - Salary		Francsicsan Sisters of Chicago Service Corporation	100.00%	41,373	41,373	18
19	V	10	Nursing - Other		Francsicsan Sisters of Chicago Service Corporation	100.00%	2,191	2,191	19
20	V	15	Emp. Ben. - HC and Programs		Francsicsan Sisters of Chicago Service Corporation	100.00%	9,553	9,553	20
21	V	17	Administrative - Salary		Francsicsan Sisters of Chicago Service Corporation	100.00%	86,075	86,075	21
22	V	19	Professional Fees		Francsicsan Sisters of Chicago Service Corporation	100.00%	18,871	18,871	22
23	V	20	Dues and Subscriptions		Francsicsan Sisters of Chicago Service Corporation	100.00%	4,208	4,208	23
24	V	21	Clerical - Salary		Francsicsan Sisters of Chicago Service Corporation	100.00%	290,554	290,554	24
25	V	21	Clerical - Other		Francsicsan Sisters of Chicago Service Corporation	100.00%	79,925	79,925	25
26	V	24	Seminar and Travel		Francsicsan Sisters of Chicago Service Corporation	100.00%	5,179	5,179	26
27	V	26	Insurance		Francsicsan Sisters of Chicago Service Corporation	100.00%	8,812	8,812	27
28	V	27	Emp. Ben. - Gen. Admin.		Francsicsan Sisters of Chicago Service Corporation	100.00%	86,961	86,961	28
29	V	30	Depreciaton		Francsicsan Sisters of Chicago Service Corporation	100.00%	17,963	17,963	29
30	V	34	Rent - Building		Francsicsan Sisters of Chicago Service Corporation	100.00%	118	118	30
31	V	35	Rent - Equipment		Francsicsan Sisters of Chicago Service Corporation	100.00%	1,612	1,612	31
32	V	17	Management Fees	645,528				(645,528)	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 645,528			$ 674,590	$ * 29,062	39

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

Facility Name & ID Number St Joseph Village of Chicago # 0046581 Report Period Beginning: 07/01/19 Ending: 06/30/20

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							3
4	James Stark, Committee Chairman		Franciscan Village	Lemont, IL	Franciscan Sisters of (	Lemont, IL	Religious Cong.	4
5	Judy Amiano, President		Mt. Alverna Village	Parma, OH	Franciscan Sisters Ch	Lemont, IL	Corp. Management	5
6	Raymond Catania, Director		Addolorata Villa	Wheeling, IL	St. James Senior Estat	Crete, IL	Ind. Living	6
7	Guy R. Alton, Director		The Village of Victory Lakes	Lindenhurst, IL	Marian Village	Homer Glen, IL	Ind. & Asst. Living	7
8	Raymond Ingham		University Place	West Lafayette, IN	Franciscan Senior Est	Louisville, KY	Ind. Living	8
9	Marianne D. Araujo		St. Joseph Village	Chicago IL	Franciscan Advisory S	Lemont, IL	Consulting Serv.	9
10	Daniel Noonan, Treasurer				St. Joseph Senior Hou	Lemont, IL	Affordable Housing	10
11	Denise Boudreau, Assistant Secretary				St. Jude House	Crown Point, IN	Dom. Viol. Shelter	11
12					Madonna Foundation	Lemont, IL	HS Foundation	12
13					Village at Mercy Creel	Normal, IL	Ind. & Asst. Living	13
14					Ancora at Mt. Alverna	Parma, OH	Memory Support	14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number St Joseph Village of Chicago # 0046581 Report Period Beginning: 07/01/19 Ending: 06/30/20

VII. RELATED PARTIES (continued)

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

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

	1	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	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

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

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

Facility Name & ID Number St Joseph Village of Chicago # 0046581 Report Period Beginning: 07/01/19 Ending: 06/30/20

VIII. ALLOCATION OF INDIRECT COSTS

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

Facility Name & ID Number St Joseph Village of Chicago # 0046581 Report Period Beginning: 07/01/19 Ending: 06/30/20

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [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 Drive
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	Expense	131,924,954	10	$ 183,742	$ 183,742	10,763,106	$ 14,991	1
2	6	Maintenance - Other	Expense	131,924,954	10	33,622		10,763,106	2,743	2
3	7	Emp. Ben. - Gen. Services	% of Salary	1,225,414	10	42,425		99,975	3,461	3
4	10	Nursing - Salary	Expense	131,924,954	10	507,116	507,116	10,763,106	41,373	4
5	10	Nursing - Other	Expense	131,924,954	10	26,851		10,763,106	2,191	5
6	15	Emp. Ben. - HC and Programs	% of Salary	1,225,414	10	117,090		99,975	9,553	6
7	17	Administrative - Salary	Expense	131,924,954	10	1,055,028	1,055,028	10,763,106	86,075	7
8	19	Professional Fees	Expense	131,924,954	10	231,305		10,763,106	18,871	8
9	20	Dues and Subscriptions	Expense	131,924,954	10	51,582		10,763,106	4,208	9
10	21	Clerical - Salary	Expense	131,924,954	10	3,561,362	3,561,362	10,763,106	290,554	10
11	21	Clerical - Other	Expense	131,924,954	10	979,651		10,763,106	79,925	11
12	24	Seminar and Travel	Expense	131,924,954	10	63,479		10,763,106	5,179	12
13	26	Insurance	Expense	131,924,954	10	108,010		10,763,106	8,812	13
14	27	Emp. Ben. - Gen. Admin.	% of Salary	1,225,414	10	1,065,899		99,975	86,961	14
15	30	Depreciaton	Expense	131,924,954	10	220,169		10,763,106	17,963	15
16	34	Rent - Building	Expense	131,924,954	10	1,452		10,763,106	118	16
17	35	Rent - Equipment	Expense	131,924,954	10	19,760		10,763,106	1,612	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 8,268,543	$ 5,307,248		$ 674,590	25

Facility Name & ID Number St Joseph Village of Chicago # 0046581 Report Period Beginning: 07/01/19 Ending: 06/30/20

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Amalgamated Bank		X	Acquisition	Varies	03/17/13	$ 9,664,936	$ 8,093,190	5/15/2047	0.0486	$ 364,383	1
2	Amalgamated Bank		X	Acquisition / Refinance	Varies	06/28/17	3,924,698	3,626,610	5/1/2047	0.0486	163,283	2
3	Huntington Bank		X	Acquisition / Refinance	Varies	06/28/17	442,186	420,954	5/1/2047	Variable	18,953	3
4	Huntington Bank		X	Acquisition / Refinance	Varies	06/28/17	1,067,093	859,236	5/1/2047	Variable	38,686	4
5	Huntington Bank		X	Acquisition / Refinance	Varies	06/28/17	2,139,479	1,433,539	5/1/2047	0.0283	64,543	5
	Working Capital											
6	Long Term Debt Continued											6
7	Wintrust Bank		X	Acquisition / Refinance	Varies	06/28/17	1,556,492	1,996,456	5/1/2047	Variable	89,887	7
8												8
9	TOTAL Facility Related						$ 18,794,883	$ 16,429,984			$ 739,735	9
	B. Non-Facility Related*											
10	Interest Income		X								(17)	10
11												11
12	Alloc. - Non-Allowable AL/IL										(372,467)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (372,484)	14
15	TOTALS (line 9+line14)						$ 18,794,883	$ 16,429,984			$ 367,251	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None Line # N/A

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

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

Facility Name & ID Number St Joseph Village of Chicago # 0046581 Report Period Beginning: 07/01/19 Ending: 06/30/20

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 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 2020 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:			
	2015		8
	2016		9
	2017		10
	2018		11
	2019		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 2019	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME St Joseph Village of Chicago COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0046581

CONTACT PERSON REGARDING THIS REPORT Denise A. Leonard

TELEPHONE (216) 274-6514 FAX #: (248) 233-7349

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

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

	(A) 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 _____ NO

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

C. **Tax Bills**

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

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

Facility Name & ID Number St Joseph Village of Chicago # 0046581 Report Period Beginning: 07/01/19 Ending: 06/30/20

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

Facility Name & ID Number St Joseph Village of Chicago # 0046581 Report Period Beginning: 07/01/19 Ending: 06/30/20

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	Landscaping - Gazebo (TC = $6,770)			2016	3,361						20
21	Boiler Room - Boiler (TC = $48,877)			2017	24,266						21
22	Boiler Room - Ejector Pump (TC = $3,782)			2017	1,878						22
23	Security System (TC = $5,045)			2017	2,505						23
24	Flooring - Carpet (TC = $3,195)			2017	1,586						24
25	Windows - Resident Rooms (TC = $2,700)			2017	1,340						25
26	Door - Front Entry (TC = $5,722)			2018	2,841						26
27	Philips Lifeline - Nurse call system (TC = $6,929)			2018	3,440						27
28	Bock Antenna - cable tv system (TC = $29,682)			2019	14,736						28
29	RA Daugherty - elevator booster pump (TC = $3,250)			2019	1,614						29
30	Edward Don - dishtable w/ sinks (TC = $5,404)			2019	2,683						30
31	Stanley Access Tech, LLC - Door (TC = $3,666)			2019	1,820						31
32	RA Daugherty Sales - Pump&Moter Elevators (TC = $3,375)			2019	1,676						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

Facility Name & ID Number St Joseph Village of Chicago # 0046581 Report Period Beginning: 07/01/19 Ending: 06/30/20

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	Current Fiscal Year Additions: 2019-2020								38
39									39
40	200 Ton Chiller Package (TC 16798)	2019	8,340						40
41	200 Ton Chiller Package (TC 12118)	2019	6,016						41
42	200 Ton Chiller Package (TC 9664)	2019	4,798						42
43	Aggreko Inv 13528962 (TC 8900)	2019	4,419						43
44	Aggreko Inv 13528912 (TC 9050)	2019	4,493						44
45	Zentel Tech Chiller (TC 20000)	2019	9,929						45
46	Aggreko 200 Ton Chiller (TC 8900)	2019	4,419						46
47	Aggreko 200 Ton Chiller (TC 3138)	2019	1,558						47
48	Ashland Plumbing (TC 8800)	2020	4,369						48
49	Broken Sewer (TC 6000)	2020	2,979						49
50	Chiller Prjoect (TC 231108)	2020	114,739						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	Depreciation			405,336		405,336		6,668,056	68
69									69
70	TOTAL (lines 4 thru 69)		$ 10,173,540	$ 405,336		$ 405,336	$	$ 6,668,056	70

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

St. Joseph Village of Chicago
Medicaid Cost Report
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Page 12 Supp 1 - CY Leasehold Improvement Additions

Desciption	Acquisiton Date	Cost	Class	Method	Capitalized		Expensed	
					Nursing Home	Other	Nursing Home	Other
200 Ton Chiller Package	7/30/2019	16,798	LIMP	Indirect	8,340	8,458		
200 Ton Chiller Package	8/26/2019	12,118	LIMP	Indirect	6,016	6,102		
200 Ton Chiller Package	8/2/2019	9,664	LIMP	Indirect	4,798	4,866		
Aggreko Inv 13528962	10/11/2019	8,900	LIMP	Indirect	4,419	4,481		
Aggreko Inv 13528912	10/11/2019	9,050	LIMP	Indirect	4,493	4,557		
Zentel Tech Chiller	8/20/2019	20,000	LIMP	Indirect	9,929	10,071		
Aggreko 200 Ton Chiller	10/30/2019	8,900	LIMP	Indirect	4,419	4,481		
Aggreko 200 Ton Chiller	12/6/2019	3,138	LIMP	Indirect	1,558	1,580		
Ashland Plumbing	1/27/2020	8,800	LIMP	Indirect	4,369	4,431		
Broken Sewer	2/25/2020	6,000	LIMP	Indirect	2,979	3,021		
Chiller Prjoect	5/31/2020	231,108	LIMP	Indirect	114,739	116,368		
		334,476			166,059	168,417	-	-

Facility Name & ID Number St Joseph Village of Chicago # 0046581 Report Period Beginning: 07/01/19 Ending: 06/30/20

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	$ 773,388	$	$	$		$	71
72	Current Year Purchases	41,499						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 814,887	$	$	$		$	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	$ 2,289	$	$	$		$	76
77	Facility	Bus	2016	34,151						77
78	Facility (TC = $66,703)	Bus	2018	33,116						78
79										79
80	TOTALS			$ 69,556	$	$	$		$	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)	$	11,199,019	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	405,336	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$	405,336	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)	$	6,668,056	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	$ 11,258,452	$	$	86
87	Non-Care Assets - CY LIMP Add.	168,417			87
88	Non-Care Assets - CY EQIP Add.	36,805			88
89	Non-Care Assets - CY AUTO Add.				89
90	Depreciation		393,129	6,467,242	90
91	TOTALS	$ 11,463,674	$ 393,129	$ 6,467,242	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.

St. Joseph Village of Chicago
Medicaid Cost Report
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Page 13 Supp 1 - CY Equipment, Funiture and Vehicle Additions

					Capitalized		Expensed	
Desciption	Acquisiton Date	Cost	Class	Method	Nursing Home	Other	Nursing Home	Other
Direct Supply Wheelchairs	7/1/2019	2,702	Equip	Indirect	2,702	-		
Provinet Computer Equipment	7/1/2019	1,310	Equip	Indirect			650	659
ProviNET Computer Equipment	7/31/2019	9,363	Equip	Indirect	4,648	4,714		
PC Connection Badge Printer	7/1/2019	2,041	Equip	Indirect			1,013	1,027
Direct Supply	11/14/2019	13,673	Equip	Indirect	6,788	6,885		
Direct Supply	11/22/2019	15,816	Equip	Indirect	7,852	7,964		
Direct Supply - Wheelchair	3/4/2020	2,507	Equip	Indirect	2,507	-		
Broiler Oven Unidine	6/30/2020	591	Equip	Indirect			293	298
Icemaker Unidine	6/30/2020	16,769	Equip	Indirect	8,325.22	8,443		
Dishes Unidine	6/30/2020	4,354	Equip	Indirect	2,161.89	2,193		
Induction Ovens Unidine	6/30/2020	6,071	Equip	Indirect	3,014.29	3,057		
Dining Equipment Unidine	6/30/2020	7,049			3,499.57	3,549		
		82,246			41,499	36,805	1,957	1,985

Facility Name & ID Number St Joseph Village of Chicago # 0046581 Report Period Beginning: 07/01/19 Ending: 06/30/20

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								5
6	See Supplemental				59			6
7	TOTAL				$ 59 **			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.	/2021	$
13.	/2022	$
14.	/2023	$

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

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

16. Rental Amount for movable equipment: $ 17,844 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.

St. Joseph Village of Chicago
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Page 14 Supplemental Schedule

Desciption	Amount	Total
Building Rental		
Franciscan Sisters of Chicago Serv Corp		-
Alloc. - Building Rent	118	118
		-
Alloc. - Non-Allowable AL / IL	(59)	(59)
		-
		-
		-
		-
		-
		-
		-
		-
		-
Total	59	59
Equipment Rental		
Franciscan Sisters of Chicago Serv Corp		-
Alloc. - Equipment Rent	1,612	1,612
		-
Equipment Rental- Dish/Rugs	10,587	10,587
Equipment Lease	16,217	16,217
		-
Alloc. - Non-Allowable AL / IL	(10,572)	(10,572)
		-
		-
		-
		-
		-
		-
Total	17,844	17,844

Facility Name & ID Number St Joseph Village of Chicago # 0046581 Report Period Beginning: 07/01/19 Ending: 06/30/20

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.

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	V10A	0.00	hrs	$ 0	4,742	$ 227,239	$ 0	4,742	$ 227,239	1
2	Licensed Speech and Language Development Therapist	V10A	0.00	hrs	0	2,082	118,503	0	2,082	118,503	2
3	Licensed Recreational Therapist	V10A	0.00	hrs	0	0	0	0			3
4	Licensed Physical Therapist	V10A	0.00	hrs	0	4,803	280,482	0	4,803	280,482	4
5	Physician Care			visits							5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation	V39	0.00	hrs	0	0	0	0			8
9	Pharmacy	V39	0.00	# of prescrpts	0	0	0	317,652		317,652	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Other (specify): LAB/RADIOLOGY	V39	0.00		0	0	0	24,182		24,182	12
13	Other (specify): BILLABLE SUPPLIES	V39	0.00		0	0	0	122,713		122,713	13
14	TOTAL				$	11,627	$ 626,224	$ 464,547	11,627	$ 1,090,771	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.

St. Joseph Village of Chicago
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Page 16 Supplemental Schedule

Description	Salaries	Supplies	Other	Total
Medical Supplies		122,713		122,713
Oxygen				-
Laboratory			12,507	12,507
Radiology			11,675	11,675
Medical Equipment Rental				-
Other				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
Total	-	122,713	24,182	146,895

STATE OF ILLINOIS

Facility Name & ID Number St Joseph Village of Chicago **#** 0046581 **Report Period Beginning:** 07/01/19 **Ending:** 06/30/20

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 06/30/20 **(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	$ 4,360	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 740,128)	1,359,891		3
4	Supply Inventory (priced at)	31,480		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	50,224		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached	47,438		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,493,393	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	290,802		13
14	Buildings, at Historical Cost	18,131,282		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	3,799,139		16
17	Accumulated Depreciation (book methods)	(13,135,298)		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 (spe See Attached			22
23	Other(specify): See Attached	53,903		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 9,139,828	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 10,633,221	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 808,478	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	68,340		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	451,835		30
31	Accrued Taxes Payable (excluding real estate taxes)	39,649		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation	3,395		34
35	Federal and State Income Taxes	6,519		35
	Other Current Liabilities(specify):			
36	See Attached			36
37	P/R Witholding / Accrued Audit	92,129		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,470,345	$	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 Attached	28,207		43
44	See Attached			44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 28,207	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,498,552	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 9,134,669	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 10,633,221	$	48

***(See instructions.)**

St. Joseph Village of Chicago
Medicaid Cost Report
07/01/19 - 06/30/20

Page 17 Supplemental Schedule

Description	Operating	Building	Total
Line 9 - Other Current Assets			
Inventories - Dietary	16,438		16,438
Inventories - Gift Shop	12,117		12,117
Inventories - Housekeeping	13,867		13,867
Inventories - Laundry and Linen	2,106		2,106
Inventories - Maintenance	2,910		2,910
Sub-Total	47,438	-	47,438
Line 23 - Long Term Assets			
Cost Settlements- Medicare	53,903		53,903
			-
			-
			-
			-
Sub-Total	53,903	-	53,903
Line 37 - Other Current Liability			
P/R Withholding - W/C	80,396		80,396
Accrued audit	11,733		11,733
			-
			-
			-
Sub-Total	92,129	-	92,129
Line 43 - Long term Liabilities			
Deferred Liabilities	28,207		28,207
			-
			-
			-
			-
Sub-Total	28,207	-	28,207

Facility Name & ID Number St Joseph Village of Chicago # 0046581 Report Period Beginning: 07/01/19 Ending: 06/30/20

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 9,679,716	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 9,679,716	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(970,800)	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)**	$ (970,800)	17
	B. Transfers (Itemize):		
18	**ILU net asset activity for the year**	425,753	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 425,753	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 9,134,669	24 *

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

Facility Name & ID Number St Joseph Village of Chicago # 0046581 Report Period Beginning: 07/01/19 Ending: 06/30/20

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,281,352	1
2	Discounts and Allowances for all Levels	(1,021,325)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,260,027	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,370,267	6
7	Oxygen	131	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,370,398	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	2,267	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio	279	15
16	Rental of Facility Space		16
17	Sale of Drugs	301,406	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	6,050	19
20	Radiology and X-Ray	12,125	20
21	Other Medical Services	459,910	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 782,037	23
	D. Non-Operating Revenue		
24	Contributions	10,590	24
25	Interest and Other Investment Income***	17	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 10,607	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	AL/IL	2,155,794	28
28a	Misc Revenue	213,443	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,369,237	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,792,306	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,599,203	31
32	Health Care	3,074,296	32
33	General Administration	3,224,640	33
	B. Capital Expense		
34	Ownership	1,565,004	34
	C. Ancillary Expense		
35	Special Cost Centers	1,200,063	35
36	Provider Participation Fee	99,900	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,763,106	40
41	**Income before Income Taxes (line 30 minus line 40)****	(970,800)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (970,800)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 701,178	44
45	Private Pay - Net Inpatient Revenue	2,394,743	45
46	Medicare - Net Inpatient Revenue	3,181,236	46
47	Other-(specify) ALL OTHER SNF/SCF IP REVENUE	905,647	47
48	Other-(specify) C/A ANCILLARY ACCOUNTS	(1,922,777)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,260,027	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

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

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

St Joseph Village of Chicago
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Page 19 Support

PG 19 Line 28 Detail

MCD ACT	DESC	BALANCE
5017.00	Room & Board - Assisted Living	2,087,585.00
5401.00	Other Resident Ancillaries- Assisted Living	67,093.00
5402.00	Other Resident Ancillaries- I L	1,116.00
Total		2,155,794.00

PG 19 Line 28A Detail

MCD ACT	DESC	BALANCE
5400	Misc. Income	184.00
5530	Rebates and Refunds	(6,244.00)
5750	Other Specify: Provider Relief Funds	212,169.00
5750.1	Other Income- Administrative	2,036.00
5750.2	Other Income-Dietary	4,462.00
5750.9	Other Income-Activities	546.00
5751	Other Income-Transportation	290.00
Total		213,443.00

Facility Name & ID Number St Joseph Village of Chicago # 0046581 Report Period Beginning: 07/01/19 Ending: 06/30/20

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	0	0	$ 0	$	1
2	Assistant Director of Nursing	1,912	2,080	78,145	37.57	2
3	Registered Nurses	23,645	25,936	976,757	37.66	3
4	Licensed Practical Nurses	2,175	2,304	66,267	28.76	4
5	CNAs & Orderlies	37,613	41,957	729,873	17.40	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	0	0	0		7
8	Rehab/Therapy Aides	0	0	0		8
9	Activity Director	1,554	1,610	38,628	23.99	9
10	Activity Assistants	0	0	0		10
11	Social Service Workers	3,594	4,020	140,561	34.97	11
12	Dietician	0	0	0		12
13	Food Service Supervisor	0	0	0		13
14	Head Cook	5,228	5,809	78,796	13.56	14
15	Cook Helpers/Assistants	1,858	2,133	39,116	18.34	15
16	Dishwashers	0	0	0		16
17	Maintenance Workers	3,756	4,109	88,842	21.62	17
18	Housekeepers	894	10,009	155,329	15.52	18
19	Laundry	2,499	2,785	38,775	13.92	19
20	Administrator	1,940	2,120	143,019	67.46	20
21	Assistant Administrator	0	0	0		21
22	Other Administrative	22,179	24,226	563,616	23.26	22
23	Office Manager	1,824	2,080	61,924	29.77	23
24	Clerical	0	0	0		24
25	Vocational Instruction	0	0	0		25
26	Academic Instruction	0	0	0		26
27	Medical Director	0	0	0		27
28	Qualified MR Prof. (QMRP)	0	0	0		28
29	Resident Services Coordinator	0	0	0		29
30	Habilitation Aides (DD Homes)	0	0	0		30
31	Medical Records	258	281	5,351	19.04	31
32	Other Health Care(specify)	0	0	0		32
33	Other(specify) See Supplemental	31,657	34,223	705,190	20.61	33
34	TOTAL (lines 1 - 33)	142,586	165,682	$ 3,910,189 *	$ 23.60	34

* 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	0	$ 0		35
36	Medical Director	0	18,000	09 - 03	36
37	Medical Records Consultant	0	0		37
38	Nurse Consultant	0	5,456	10 - 03	38
39	Pharmacist Consultant	0	4,328	10 - 03	39
40	Physical Therapy Consultant	0	0	10a - 03	40
41	Occupational Therapy Consultant	0	0	10a - 03	41
42	Respiratory Therapy Consultant	0	0	10a - 03	42
43	Speech Therapy Consultant	0	0	10a - 03	43
44	Activity Consultant	0	1,372	11 - 03	44
45	Social Service Consultant	0	2,075	12 - 03	45
46	Other(specify) See Supplemental	0	285,586	Various	46
47		0	0		47
48		0	0		48
49	TOTAL (lines 35 - 48)		$ 316,817		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	4,160	$ 157,195	V10-3	50
51	Licensed Practical Nurses			V10-3	51
52	Certified Nurse Assistants/Aides	1,089	34,860	V10-3	52
53	TOTAL (lines 50 - 52)	5,249	$ 192,055		53

St. Joseph Village of Chicago
Medicaid Cost Report
07/01/19 - 06/30/20

Page 20 Supplemental Schedule

Description	CC Reference	Hours Worked	Hours Paid	Salary	Average Rate	Hours Paid	Contracted Cost
Other Staffing							
Marketing and Advertising	43	2,622	2,875	91,298	31.76		
Barber and Beauty	43				-		
Gift Shop Salary	43				-		
Development	43				-		
Assisted Living	43	29,035	31,348	613,892	19.58		
Independent Living	43				-		
Total		31,657	34,223	705,190	20.61		
Other Contract Services							
Dietary Management	01						52,011
Dietary Labor	01						218,025
Priest	12						13,850
Organists	12						1,700
Total						-	285,586

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Brian Celerio	Administrator	0	$ 143,019
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 143,019

B. Administrative - Other

Description	Amount
Franciscan Sisters of Chicago Service Corp.	$ 645,528
TOTAL (agree to Schedule V, line 17, col. 3)	$ 645,528
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Ability Network	Financial Consultant	$ 5,746
Plante Moran	Accounting	11,327
Plante Moran	Accounting - Cost Report	8,268
Probusiness/ Ultipro	Payroll Processing	18,443
Consultant	Administrative	5,100
Markoff Law LLC	Billing	4,333
Kopon Airdo, LLC	Legal	4,499
Rolf Goffman Martin Lang LLP	Legal	232
Angelica Felix	Legal	1,413
Adam M. Stern	Legal	2,677
Software Maintenance	Clinical	1,777
Software Maintenance	Financial	2,678
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 66,493

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 0
Unemployment Compensation Insurance	
FICA Taxes	292,367
Employee Health Insurance	406,068
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Disability Insurance	12,201
Life Insurance	5,147
Retirement Benefits	81,747
Other Benefits	88,414
Nonallowable Benefits	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 885,943

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	$ 7,745
Advertising: Employee Recruitment	6,049
Health Care Worker Background Check	1,494
(Indicate # of checks performed)	
Patient Background Checks	
Dues and Subscriptions	17,451
Alloc. - FSCSC (See Page 6A Alloc.)	4,208
Alloc. - Non Allowable AL / IL (See Page 5A)	(9,065)
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 27,882

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,420
Alloc. - FSCSC (See Page 6A Alloc.)	5,179
Alloc. - Non Allowable AL / IL (See Page 5A)	(2,455)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,144

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number St Joseph Village of Chicago # 0046581 Report Period Beginning: 07/01/19 Ending: 06/30/20

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. **Life Services Network, $7,745**

(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 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **22,575** 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. $ **99,900**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **Yes - 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. $ **4,462**

(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 Basis)**

(18) Have all costs which do not relate to the provision of long term care been adjusted out 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.