



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

# 0027045 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

III. STATISTICAL DATA

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

N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>20</u>	Skilled (SNF)	<u>20</u>	<u>7,320</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>39</u>	Intermediate (ICF)	<u>39</u>	<u>14,274</u>	3
4		Intermediate/DD			4
5	<u>7</u>	Sheltered Care (SC)	<u>7</u>	<u>2,562</u>	5
6		ICF/DD 16 or Less			6
7	<u>66</u>	TOTALS	<u>66</u>	<u>24,156</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment			
		Medicaid Recipient	Private Pay	Other	
8	SNF				8
9	SNF/PED				9
10	ICF	<u>18,828</u>	<u>1,776</u>		<u>20,604</u>
11	ICF/DD				11
12	SC		<u>1,246</u>		<u>1,246</u>
13	DD 16 OR LESS				13
14	TOTALS	<u>18,828</u>	<u>3,022</u>		<u>21,850</u>

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.45%

D. How many bed-hold days during this year were paid by the Department?

8 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

NONE

F. Does the facility maintain a daily midnight census?

YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES  NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES  NO

I. On what date did you start providing long term care at this location?

Date started 01/09/1967

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

YES  Date \_\_\_\_\_ NO

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

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

Medicare Intermediary \_\_\_\_\_

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

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

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	368,701	4,863	85,044	458,608		458,608	(63,627)	394,981		1
2	Food Purchase		117,227		117,227		117,227		117,227		2
3	Housekeeping		22,303	257,215	279,518		279,518		279,518		3
4	Laundry	83,766	13,091		96,857		96,857	(6,850)	90,007		4
5	Heat and Other Utilities			232,375	232,375		232,375	(113,362)	119,013		5
6	Maintenance	191,660	58,613	128,771	379,044		379,044	(16,962)	362,082		6
7	Other (specify):*	65,486		15,035	80,521		80,521		80,521		7
8	<b>TOTAL General Services</b>	<b>709,613</b>	<b>216,097</b>	<b>718,440</b>	<b>1,644,150</b>		<b>1,644,150</b>	<b>(200,801)</b>	<b>1,443,349</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			2,400	2,400		2,400		2,400		9
10	Nursing and Medical Records	1,883,376	80,800	185,507	2,149,683		2,149,683		2,149,683		10
10a	Therapy	82,744			82,744		82,744		82,744		10a
11	Activities	100,266	18,538	2,620	121,424		121,424		121,424		11
12	Social Services	29,601		880	30,481		30,481		30,481		12
13	CNA Training										13
14	Program Transportation			4,821	4,821		4,821		4,821		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>2,095,987</b>	<b>99,338</b>	<b>196,228</b>	<b>2,391,553</b>		<b>2,391,553</b>		<b>2,391,553</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative			79,204	79,204		79,204		79,204		17
18	Directors Fees										18
19	Professional Services			63,536	63,536		63,536		63,536		19
20	Dues, Fees, Subscriptions & Promotions			71,925	71,925		71,925	(57,642)	14,283		20
21	Clerical & General Office Expenses	297,548	33,041	109,279	439,868		439,868		439,868		21
22	Employee Benefits & Payroll Taxes			689,337	689,337		689,337		689,337		22
23	Inservice Training & Education			4,686	4,686		4,686		4,686		23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation			14,463	14,463		14,463		14,463		25
26	Insurance-Prop.Liab.Malpractice			43,854	43,854		43,854	(7,056)	36,798		26
27	Other (specify):* <b>Bad Debts</b>			23,291	23,291		23,291	(23,291)			27
28	<b>TOTAL General Administration</b>	<b>297,548</b>	<b>33,041</b>	<b>1,099,575</b>	<b>1,430,164</b>		<b>1,430,164</b>	<b>(87,989)</b>	<b>1,342,175</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>3,103,148</b>	<b>348,476</b>	<b>2,014,243</b>	<b>5,465,867</b>		<b>5,465,867</b>	<b>(288,790)</b>	<b>5,177,077</b>		<b>29</b>

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

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

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			394,533	394,533	394,533	(50,034)	344,499				30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			394,533	394,533	394,533	(50,034)	344,499				37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			222,931	222,931	222,931		222,931				42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			222,931	222,931	222,931		222,931				44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,103,148	348,476	2,631,707	6,083,331	6,083,331	(338,824)	5,744,507				45

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

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

# 0027045

Report Period Beginning: 01/01/2012

Ending: 12/31/2012

**VI. ADJUSTMENT DETAIL**

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

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

		1	2	3	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(63,627)	1		4
5	Telephone, TV & Radio in Resident Rooms	(5,670)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(6,850)	4		8
9	Non-Straightline Depreciation	(50,034)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions	(107,692)	5		15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(16,962)	6		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance	(7,056)	26		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(23,291)	27		24
25	Fund Raising, Advertising and Promotional	(57,642)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pages 5A and 5B				29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (338,824)		\$	30

<b>BHF USE ONLY</b>						
48		49		50		51
						52

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

		1	2	
		<b>Amount</b>	<b>Reference</b>	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (338,824)		37

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

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

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

St Josephs Home F/T Elderly

ID# 0027045

Report Period Beginning: 01/01/2012

Ending: 12/31/2012

Sch. V Line

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

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

## STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

01/01/2012

Ending:

12/31/2012

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

	Operating Expenses	PAGES	PAGE	SUMMARY										
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	(63,627)	0	0	0	0	0	0	0	0	0	0	(63,627)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(6,850)	0	0	0	0	0	0	0	0	0	0	(6,850)	4
5	Heat and Other Utilities	(113,362)	0	0	0	0	0	0	0	0	0	0	(113,362)	5
6	Maintenance	(16,962)	0	0	0	0	0	0	0	0	0	0	(16,962)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(200,801)</b>	<b>0</b>	<b>(200,801)</b>	<b>8</b>									
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(57,642)	0	0	0	0	0	0	0	0	0	0	(57,642)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(7,056)	0	0	0	0	0	0	0	0	0	0	(7,056)	26
27	Other (specify):*	(23,291)	0	0	0	0	0	0	0	0	0	0	(23,291)	27
28	<b>TOTAL General Administration</b>	<b>(87,989)</b>	<b>0</b>	<b>(87,989)</b>	<b>28</b>									
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(288,790)</b>	<b>0</b>	<b>(288,790)</b>	<b>29</b>									

## STATE OF ILLINOIS

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

Report Period Beginning:

01/01/2012 Ending:

Summary B

12/31/2012

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
30	Depreciation	(50,034)	0	0	0	0	0	0	0	0	0	0	(50,034)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(50,034)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(50,034)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	(sum of lines 29, 37 & 44)	(338,824)	0	0	0	0	0	0	0	0	0	0	(338,824)	45

**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
		Little Sisters of the Poor - St. Mary's Home	Chicago, IL	Little Sisters of the Poor - Chicago Province, Inc.	Palatine, IL	Religious Order

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	19 Payroll Processing	\$ 15,481	Little Sisters of the Poor - Chicago Province, Inc.	0.00%	\$ 15,481	\$	1
2	V	19 Corporate Compliance	5,750	Little Sisters of the Poor - Chicago Province, Inc.	0.00%	5,750		2
3	V	19 Computer Consulting - IT	4,500	Little Sisters of the Poor - Chicago Province, Inc.	0.00%	4,500		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	<b>Total</b>		\$ 25,731			\$ 25,731	\$ *	14

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

Facility Name & ID Number

St Josephs Home F/T Elderly

# 0027045

Report Period Beginning:

01/01/2012

Ending:

12/31/2012

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference
						Hours	Percent	Description	Amount	
1									\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

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

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

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

# 0027045

Report Period Beginning:

01/01/2012

Ending: 2/31/2012

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number

St Josephs Home F/T Elderly

# 0027045

Report Period Beginning:

01/01/2012

Ending:

12/31/2012

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

1	Name of Lender	2		3	4	5	6		8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required				Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
<b>A. Directly Facility Related</b>																	
<b>Long-Term</b>																	
1	Little Sisters of the Poor						\$	\$			\$						
2	- Chicago Province, Inc.	X		Construction	NONE	Various	2,517,300	2,517,300	Various	0.0300							
3																	
4																	
5																	
<b>Working Capital</b>																	
6	Little Sisters of the Poor																
7	- Chicago Province, Inc.	X		Working Capital	NONE	Various	3,943,770	3,943,770	Various	0.0300							
8																	
9	<b>TOTAL Facility Related</b>						\$ 6,461,070	\$ 6,461,070			\$						
<b>B. Non-Facility Related*</b>																	
10	Little Sisters of the Poor																
11	- Chicago Province, Inc.	X		Convent Allocation	NONE	Various	1,238,930	1,238,930	Various	0.0300							
12																	
13																	
14	<b>TOTAL Non-Facility Related</b>						\$ 1,238,930	\$ 1,238,930			\$						
15	<b>TOTALS (line 9+line14)</b>						\$ 7,700,000	\$ 7,700,000			\$						

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

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

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

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

**B. Real Estate Taxes**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>			
1.	Real Estate Tax accrual used on 2011 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 2012 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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>	\$			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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>	\$			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:		2007	_____	8	
		2008	_____	9	
		2009	_____	10	
		2010	_____	11	
		2011	_____	12	
<b>FOR BHF USE ONLY</b>					
		13	FROM R. E. TAX STATEMENT FOR 2011 \$		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.**

## 2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME St Josephs Home F/T Elderly COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0027045

CONTACT PERSON REGARDING THIS REPORT Mother Marguerite McCarthy

TELEPHONE (847) 358-5700 FAX #: (847) 358-5719

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

Enter the tax index number and real estate tax assessed for 2011 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 2011.

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

**B. Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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

**X. BUILDING AND GENERAL INFORMATION:**

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

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

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

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

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

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

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

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Existing Structure</u>	<u>653,400</u>	<u>1966</u>	<u>\$ 76,284</u>	1
2					2
3	<b>TOTALS</b>	<b>653,400</b>		<b>\$ 76,284</b>	3

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	66	1966	1966	\$ 3,221,573	\$	40	\$	\$	\$ 3,221,573	4
5										5
6										6
7										7
8										8
<b>Improvement Type**</b>										
9	Health Related Renovation		1967	24,177		40			24,177	9
10	Health Related Renovation		1968	34,542		40			34,542	10
11	Health Related Renovation		1969	26,308		40			26,308	11
12	Health Related Renovation		1970	40,716		40			40,716	12
13	Health Related Renovation		1971	22,307	268	40		(268)	22,307	13
14	Health Related Renovation		1972	119,419	2,846	40	6	(2,840)	119,419	14
15	Health Related Renovation		1974	10,272	306	40	257	(49)	10,102	15
16	Health Related Renovation		1975	9,671	288	40	242	(46)	9,317	16
17	Health Related Renovation		1976	965	29	40	24	(5)	907	17
18	Health Related Renovation		1978	44,279	1,319	40	1,107	(212)	39,423	18
19	Interior Renovation - Conversion from Wards to Rooms		1983	3,663,633	109,154	40	91,591	(17,563)	2,768,416	19
20	New Fire Door System		1984	25,217	751	40	630	(121)	18,206	20
21	Complete Boiler Renovation		1985	470,291	14,012	40	11,757	(2,255)	327,474	21
22	Electrical Repairs & New Cooling System for Boilers		1987	106,618	3,177	40	2,666	(511)	68,725	22
23	Concrete Restoration		1990	111,172	3,312	40	2,779	(533)	63,094	23
24	Exterior Renovation Including New Windows		1991	317,750	9,467	40	7,944	(1,523)	172,056	24
25	Driveway Restored		1991	32,334		10			32,334	25
26	Sewer Renovation		1992	13,999	417	40	350	(67)	7,208	26
27	Asbestos Removal & Central Air Conditioning		1992	1,051,235	31,320	40	26,281	(5,039)	550,778	27
28	Remodel Center & West Wings		1993	2,619,173	78,035	40	65,479	(12,556)	1,271,265	28
29	Pond Dredge		1995	24,711		14			24,711	29
30	Back Driveway Replaced		1996	57,358		10			57,358	30
31	Patio and Sidewalk Restoration		1998	27,055		10			27,055	31
32	Asphalt Paving		1998	1,888		10			1,888	32
33	Front Walkway Lighting Restoration		1998	2,892		10			2,892	33
34	Brick Paving, Concrete and Electric for Front Walkway/Sitting Area		2000	11,634		10			11,634	34
35	Evergreens, Statue and Pedestal		2003	6,168	368	20	309	(59)	2,931	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 Josephs Home F/T Elderly

# 0027045

Report Period Beginning:

01/01/2012

Ending:

12/31/2012

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Handicap Switches to Front Door	2004	\$ 1,326	\$ 40	40	\$ 34	\$ (6)	\$ 257	37
38	New Flooring	2006	1,339	40	40	34	(6)	220	38
39	Asphalt Replacement	2008	7,063	842	10	706	(136)	3,177	39
40	Garage Roof	2009	13,039	388	40	326	(62)	1,141	40
41	Parking Lot Lights and Poles	2009	35,825	2,135	20	1,791	(344)	6,269	41
42	Concrete and Curb Replacement	2009	15,752	1,877	10	1,575	(302)	5,513	42
43	Building Roof Replacement	2011	757,126	22,558	40	18,928	(3,630)	28,392	43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51	2007 Cap Bldg Repairs - Roof and Electrical Repairs	2007	17,788		5	1,777	1,777	17,788	51
52	2008 Cap Bldg Repairs - Storm Sewer Repair	2008	3,067		5	613	613	2,759	52
53	2009 Cap Bldg Repairs - Doors, Fire Alarm, HVAC and Plumbing	2009	29,121		5	5,824	5,824	20,384	53
54	2010 Cap Bldg Repairs - HVAC, Plumbing and Electric Repairs	2010	24,655		5	4,931	4,931	12,328	54
55	2011 Cap Bldg Repairs - Plumbing and HVAC Repairs	2011	7,424		5	1,485	1,485	2,227	55
56	2012 Cap Bldg Repairs - Plumbing and HVAC Repairs	2012	14,233		5	1,423	1,423	1,423	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	<b>TOTAL (lines 4 thru 69)</b>		\$ 13,025,115	\$ 282,949		\$ 250,869	\$ (32,080)	\$ 9,058,694	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$	\$	\$	\$		\$	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$	\$	\$	\$		\$	75

D. Vehicle Costs. (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Care Use	1989 M/F Diesel Tractor	1989	\$ 21,817	\$	\$	\$	4	\$ 21,817	76
77	Care Use	1994 Lewis Riding Mower	1994	5,807				4	5,807	77
78	Care Use	1998 Steer-Rite Pallet Truck	1998	470				4	470	78
79	Care Use	1996 Great Chariot Mower	1999	6,521				4	6,521	79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

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

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

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$	\$	\$	\$		\$	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$	\$	\$	\$		\$	75

D. Vehicle Costs. (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Care Use	1996 Pontiac Grand Prix	2002	\$ 6,168	\$	\$	\$	4	\$ 6,168	76
77	Care Use	2004 Ford Taurus	2004	17,647				4	17,647	77
78	Care Use	2005 John Deere 757 Mower	2005	6,312				4	6,312	78
79	Care Use	2005 Ford E450 Bus	2005	47,077				4	47,077	79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

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

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

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

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	\$ 920,408	\$ 101,157	\$ 84,881	\$ (16,276)	10 Years	\$ 513,310	71
72	Current Year Purchases	172,790	10,427	8,749	(1,678)	10 Years	8,749	72
73	Fully Depreciated Assets	728,171				10 Years	728,171	73
74								74
75	TOTALS	\$ 1,821,369	\$ 111,584	\$ 93,630	\$ (17,954)		\$ 1,250,230	75

D. Vehicle Costs. (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Care Use	2006 Chrysler Town & Country	2006	\$ 18,627	\$	\$	\$	4	\$ 18,627	76
77	Care Use	2008 Ford E350 Van	2007	25,605				4	25,605	77
78	Care Use	2008 Ford F250 Truck w/Plow	2007	25,829				4	25,829	78
79										79
80	TOTALS			\$ 181,880	\$	\$	\$		\$ 181,880	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)	\$ 15,104,648	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 394,533	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 344,499	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (50,034)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 10,490,804	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Bldg - Convent Allocation Various	\$ 2,479,142	\$ 48,133	\$ 1,661,428	86
87	Equip - Convent Allocation Various	349,253	17,954	239,735	87
88	Vehicles - Convent Allocation Various	34,876		34,876	88
89					89
90					90
91	TOTALS	\$ 2,863,271	\$ 66,087	\$ 1,936,039	91

G. Construction-in-Progress

	Description	Cost	
92	Mechanical Systems Update	\$ 165,696	92
93			93
94			94
95		\$ 165,696	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.

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

# 0027045

Report Period Beginning:

01/01/2012

Ending: 12/31/2012

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: \_\_\_\_\_

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

If NO, see instructions.

YES  NO

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

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

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

12. \_\_\_\_\_ /2013 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2014 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2015 \$ \_\_\_\_\_

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

This amount was calculated by dividing the total amount to be amortized

by the length of the lease \_\_\_\_\_.

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

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

15. Is Movable equipment rental included in building rental? \_\_\_\_\_

YES  NO

16. Rental Amount for movable equipment: \$ \_\_\_\_\_

Description: \_\_\_\_\_

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

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

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

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

Facility Name & ID Number St Josephs Home F/T Elderly # 0027045 Report Period Beginning: 01/01/2012 Ending: 12/31/2012  
**XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)**

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

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

**ALLOCATION OF COSTS (d)**

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	<b>TOTALS</b>	\$	\$	\$	\$
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**

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

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

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

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

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

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

Facility Name & ID Number **St Josephs Home F/T Elderly**# **0027045**Report Period Beginning: **01/01/2012**

Ending:

**12/31/2012****XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/2012**

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 684,293	\$	1
2	Cash-Patient Deposits	34,924		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 15,000 )	562,092		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments	10,320		5
6	Prepaid Insurance	36,889		6
7	Other Prepaid Expenses	10,186		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <b>Donations Receivable</b>	48,022		9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 1,386,726	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	111,387		13
14	Buildings, at Historical Cost	15,407,969		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,387,378		16
17	Accumulated Depreciation (book methods)	(12,369,934)		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): <b>Construction in Progress</b>	165,696		23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 5,702,496	\$	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 7,089,222	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 148,919	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	34,924		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	143,232		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 327,075	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	7,700,000		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 7,700,000	\$	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 8,027,075	\$	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ (937,853)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 7,089,222	\$	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ 137,959	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ 137,959	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	(1,075,812)	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	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ (1,075,812)	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	23
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ (937,853)	24 *

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

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

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

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

		1	
<b>I. Revenue</b>		<b>Amount</b>	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 2,692,670	1
2	Discounts and Allowances for all Levels	(74,833)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 2,617,837</b>	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$</b>	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$</b>	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	2,388,890	24
25	Interest and Other Investment Income***	792	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 2,389,682</b>	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$</b>	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 5,007,519</b>	30

		2	
<b>II. Expenses</b>		<b>Amount</b>	
<b>A. Operating Expenses</b>			
31	General Services	1,644,150	31
32	Health Care	2,391,553	32
33	General Administration	1,430,164	33
<b>B. Capital Expense</b>			
34	Ownership	394,533	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers		35
36	Provider Participation Fee	222,931	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 6,083,331</b>	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>(1,075,812)</b>	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ (1,075,812)</b>	43

<b>III. Net Inpatient Revenue detailed by Payer Source</b>			
44	Medicaid - Net Inpatient Revenue	\$ 2,343,857	44
45	Private Pay - Net Inpatient Revenue	273,980	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	<b>\$ 2,617,837</b>	49

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

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

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

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

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

# **0027045**

Report Period Beginning: **01/01/2012**

Ending:

**12/31/2012**

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4	
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing				1
2	Assistant Director of Nursing	1,776	2,072	70,643	34.09
3	Registered Nurses	17,998	19,855	572,904	28.85
4	Licensed Practical Nurses	10,328	11,207	296,986	26.50
5	CNAs & Orderlies	54,696	59,859	910,175	15.21
6	CNA Trainees				6
7	Licensed Therapist				7
8	Rehab/Therapy Aides	4,121	4,983	82,744	16.61
9	Activity Director	2,060	2,232	47,462	21.26
10	Activity Assistants	3,242	4,088	52,804	12.92
11	Social Service Workers	1,201	1,336	29,601	22.16
12	Dietician				12
13	Food Service Supervisor				13
14	Head Cook				14
15	Cook Helpers/Assistants	27,889	31,419	368,701	11.73
16	Dishwashers				16
17	Maintenance Workers	9,085	10,062	191,660	19.05
18	Housekeepers				18
19	Laundry	6,598	7,272	83,766	11.52
20	Administrator				20
21	Assistant Administrator				21
22	Other Administrative				22
23	Office Manager				23
24	Clerical	13,204	14,795	297,548	20.11
25	Vocational Instruction				25
26	Academic Instruction				26
27	Medical Director				27
28	Qualified MR Prof. (QMRP)				28
29	Resident Services Coordinator				29
30	Habilitation Aides (DD Homes)				30
31	Medical Records	1,830	2,098	32,668	15.57
32	Other Health Care(specify)				32
33	Other(specify) <u>Security Guards</u>	3,818	4,336	65,486	15.10
34	TOTAL (lines 1 - 33)	157,846	175,614	\$ 3,103,148 *	\$ 17.67

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

\*\* See instructions.

**B. CONSULTANT SERVICES**

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	146	\$ 5,840	1 - 3
36	Medical Director	96	2,400	9 - 3
37	Medical Records Consultant	19	1,110	10 - 3
38	Nurse Consultant			38
39	Pharmacist Consultant	96	4,256	10 - 3
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant	16	800	11 - 3
45	Social Service Consultant	16	880	12 - 3
46	Other(specify) <u>One Sister Acting</u>			46
47	<u>as Director of Nursing at Stipend +</u>			47
48	<u>Insurance + Room &amp; Board</u>	2,080	40,589	10 - 3
49	TOTAL (lines 35 - 48)	2,469	\$ 55,875	49

**C. CONTRACT NURSES**

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

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

# 0027045

Report Period Beginning: 01/01/2012

Ending: 12/31/2012

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
			\$	Workers' Compensation Insurance	\$ 52,922	IDPH License Fee	\$	
				Unemployment Compensation Insurance		Advertising: Employee Recruitment	419	
				FICA Taxes	231,727	Health Care Worker Background Check	550	
				Employee Health Insurance	298,586	(Indicate # of checks performed <u>17</u> )		
				Employee Meals		<u>Patient Background Checks</u>		
				Illinois Municipal Retirement Fund (IMRF)*		<u>Public Relations</u>	57,642	
				<u>Retirement Plan</u>	92,673	<u>Subscriptions</u>	3,301	
				<u>Employee Physicals</u>	1,970	<u>Licenses and Fees</u>	4,210	
				<u>Employee Dental Insurance</u>	9,459	<u>Dues - Life Services Network of IL</u>	2,512	
				<u>Employee Life Insurance</u>	2,000	<u>Dues - Misc</u>	3,291	
						Less: <u>Public Relations Expense</u>	(57,642)	
						<u>Non-allowable advertising</u>	( )	
						<u>Yellow page advertising</u>	( )	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)						TOTAL (agree to Sch. V, line 20, col. 8)		
					\$ 689,337	\$ 14,283		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description	Amount			Description	Line #	Amount	Description	Amount
<u>Two Sisters Acting as Administrator and Assistant Administrator - Stipend at \$750 for 12 Months Per Sister</u>	\$ 18,000						Out-of-State Travel	\$
<u>Health Insurance for 12 Months Per Sister</u>	13,221							
<u>Room and Board for 12 Months Per Sister</u>	47,983						In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)								
							Seminar Expense	
C. Professional Services				TOTAL			Entertainment Expense	
Vendor/Payee	Type	Amount		\$			( )	
<u>NSN</u>	<u>Unemploy Comp Consult</u>	\$ 800					TOTAL (agree to Sch. V, line 24, col. 8)	
<u>LSP - Chicago Province, Inc.</u>	<u>Payroll Processing</u>	15,481					\$	
<u>Varey &amp; Vaccariello CPAs PC</u>	<u>Accounting and Auditing</u>	36,800						
<u>LSP - Chicago Province, Inc.</u>	<u>Corporate Compliance</u>	5,750						
<u>Jackson Lewis</u>	<u>Legal (Care Related)</u>	205						
<u>LSP - Chicago Province, Inc.</u>	<u>Computer Consulting</u>	4,500						
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)								
				\$ 63,536				

\* Attach copy of IMRF notifications

\*\*See instructions.

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

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

Facility Name &amp; ID Number St Josephs Home F/T Elderly

# 0027045

Report Period Beginning: 01/01/2012 Ending: 12/31/2012

## XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No  
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 16,763 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 222,931  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? Yes For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? No Indicate the amount. \$ 0
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? 25% for  
d. Have vehicle usage logs been maintained? Yes  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?  
**g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: Varey & Vaccariello CPAs PC
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.