

Facility Name & ID Number St Joseph Village of Chicago

0046581 Report Period Beginning: 07/01/13 Ending: 06/30/14

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	54	Skilled (SNF)	54	19,710	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	54	TOTALS	54	19,710	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	1,555	7,664	6,953	16,172	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	1,555	7,664	6,953	16,172	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.05%

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

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

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

N/A

F. Does the facility maintain a daily midnight census?

Yes

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

YES 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 01/13/06

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

YES Date New Construction NO

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

YES NO If YES, enter number of beds certified 54 and days of care provided 6,130

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 06/30/14 Fiscal Year: 06/30/14

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

Facility Name & ID Number St Joseph Village of Chicago # 0046581 Report Period Beginning: 07/01/13 Ending: 06/30/14

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	255,797	41,643	198,392	495,832	495,832	(200,727)	295,105			1
2	Food Purchase		256,640		256,640	256,640	(111,491)	145,149			2
3	Housekeeping	150,829	23,468		174,297	174,297	(87,763)	86,534			3
4	Laundry	30,713	15,136		45,849	45,849	(18,561)	27,288			4
5	Heat and Other Utilities			231,931	231,931	231,931	(118,913)	113,018			5
6	Maintenance	81,154	25,316	94,325	200,795	200,795	(97,320)	103,475			6
7	Other (specify):* See Supplemental										7
8	TOTAL General Services	518,493	362,203	524,648	1,405,344	1,405,344	(634,774)	770,570			8
	B. Health Care and Programs										
9	Medical Director			12,000	12,000	12,000		12,000			9
10	Nursing and Medical Records	1,692,464	66,670	19,271	1,778,405	1,778,405	(67,803)	1,710,602			10
10a	Therapy	82,975	815	754	84,544	84,544		84,544			10a
11	Activities	73,852	8,208	810	82,870	82,870	(22,820)	60,050			11
12	Social Services	120,998	6,347	23,433	150,778	150,778	(100,486)	50,292			12
13	CNA Training										13
14	Program Transportation			1,094	1,094	1,094	(1,094)				14
15	Other (specify):* See Supplemental										15
16	TOTAL Health Care and Programs	1,970,289	82,040	57,362	2,109,691	2,109,691	(192,204)	1,917,487			16
	C. General Administration										
17	Administrative	120,098		528,068	648,166	648,166	(292,518)	355,648			17
18	Directors Fees										18
19	Professional Services			40,095	40,095	40,095	(21,759)	18,336			19
20	Dues, Fees, Subscriptions & Promotions			27,420	27,420	27,420	(8,203)	19,217			20
21	Clerical & General Office Expenses	232,989	46,629	68,634	348,252	348,252	(127,498)	220,754			21
22	Employee Benefits & Payroll Taxes			835,688	835,688	835,688		835,688			22
23	Inservice Training & Education			6,463	6,463	6,463	(2,616)	3,847			23
24	Travel and Seminar			4,926	4,926	4,926	(1,655)	3,271			24
25	Other Admin. Staff Transportation			1,159	1,159	1,159	(469)	690			25
26	Insurance-Prop.Liab.Malpractice			133,106	133,106	133,106	(34,848)	98,258			26
27	Other (specify):* See Supplemental										27
28	TOTAL General Administration	353,087	46,629	1,645,559	2,045,275	2,045,275	(489,566)	1,555,709			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,841,869	490,872	2,227,569	5,560,310	5,560,310	(1,316,544)	4,243,766			29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			836,569	836,569		836,569	(421,233)	415,336			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			864,330	864,330		864,330	(437,123)	427,207			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			33,496	33,496		33,496	(9,329)	24,167			35
36	Other (specify):* See Supplemental											36
37	TOTAL Ownership			1,734,395	1,734,395		1,734,395	(867,686)	866,709			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		325,841	643,173	969,014		969,014		969,014			39
40	Barber and Beauty Shops			23,326	23,326		23,326	(23,326)				40
41	Coffee and Gift Shops		592		592		592	(592)				41
42	Provider Participation Fee			90,860	90,860		90,860		90,860			42
43	Other (specify):* See Supplemental	600,155	54,560	70,009	724,724		724,724	(724,724)				43
44	TOTAL Special Cost Centers	600,155	380,993	827,368	1,808,516		1,808,516	(748,642)	1,059,874			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	3,442,024	871,865	4,789,332	9,103,221		9,103,221	(2,932,872)	6,170,349			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
07/01/13 - 06/30/14**

Page 4 Supplemental Schedule

Description	Salaries	Supplies	Other
Line 36 Detailed			
Total	-	-	-
Line 43 Detailed			
Assisted Living	539,416	26,334	76
Marketing	60,739	26,187	69,934
Fundraising		2,039	
Total	600,155	54,560	70,009

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,584)	02		4
5	Telephone, TV & Radio in Resident Rooms	(12,138)	21		5
6	Rented Facility Space	(5,425)	06		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(3,850)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(34,675)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Supplemental	(2,707,814)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (2,766,486)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(166,386)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (166,386)		36
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (2,932,872)		37

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

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

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		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

BHF USE ONLY							
48		49		50		51	

St Joseph Village of Chicago

ID# 0046581

Report Period Beginning: 07/01/13

Ending: 06/30/14

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Deli / Snack Shop Revenue (To Extent of Expense)	\$ (592)	41	1
2	Deli / Snack Shop Revenue (To Extent of Revenue)	(10,178)	02	2
3	Beauty Shop Revenue (T Extent of Expense)	(23,326)	40	3
4	Activity Revenue	(1,195)	11	4
5	Transportation Revenue	(1,094)	14	5
6	Copy Revenue	(411)	21	6
7	Jury Duty Revenue	(17)	10	7
8	Space Rental Revenue	(425)	06	8
9	Other Income	(200)	21	9
10	Cable TV	(4,290)	05	10
11	Theft Loss	(595)	10	11
12	Professional Fees	(15,256)	19	12
13	Dues and Subscriptions	(1,650)	20	13
14	Office	(2,350)	21	14
15	Seminars	(1,129)	24	15
16	Other Non-Allowable Expenses (Detailed Line 43)	(724,724)	43	16
17	Mission Integration	(66,278)	12	17
18	Capitalized Assets Expensed < \$2,500 Cost	3,560	06	18
19				19
20				20
21				21
22				22
23				23
24				24
25	Dietary - Indirect Allocation	(200,727)	01	25
26	Food Purchases - Indirect Allocation	(98,729)	02	26
27	Housekeeping - Indirect Allocation	(87,763)	03	27
28	Laundry - Indirect Allocation	(18,561)	04	28
29	Heat and Other Utilities - Indirect Allocation	(114,623)	05	29
30	Maintenance - Indirect Allocation	(95,030)	06	30
31	Medical Director - Indirect Allocation	0	09	31
32	Nursing and Medical Records - Indirect Allocation	(67,191)	10	32
33	Rehab Aides - Indirect Allocation	0	10a	33
34	Activities - Indirect Allocation	(21,625)	11	34
35	Social Services - Indirect Allocation	(34,208)	12	35
36	Program Transportation - Indirect Allocation	0	14	36
37	Administrative - Indirect Allocation	(126,132)	17	37
38	Professional Fees - Indirect Allocation	(6,503)	19	38
39	Dues and Subscriptions - Indirect Allocation	(6,553)	20	39
40	Clerical & General Office - Indirect Allocation	(77,724)	21	40
41	Inservice Training and Education - Indirect Alloc	(2,616)	23	41
42	Travel and Seminar - Indirect Allocation	(526)	24	42
43	Other Admin Staff Transportation - Indirect Alloc	(469)	25	43
44	Insurance - Indirect Allocation	(34,848)	26	44
45	Depreciation - Indirect Allocation	(421,233)	30	45
46	Interest - Indirect Allocation	(433,273)	32	46
47	Rent - Facility and Grounds - Indirect Allocation	0	34	47
48	Rent - Equipment and Vehicles - Indirect Alloc	(9,329)	35	48
49	Total	(2,707,814)		49

**St Joseph Village of Chicago
Medicaid Cost Report
07/01/13 - 06/30/14**

Page 5 Supplementary

Description	Cost Center	Total Salary	Total Expenses (Allowable)	Direct Nusing Home Salary	Direct Nursing Home Other Expenses	Expenses For Allocation	Allocation Method	Allocation Basis Nursing Home	Allocation Basis Total	Allocated Plus Direct		Allocated Plus Direct		Total Balanced	Nursing Home	
										Nursing Home Salary	Other Salary	Nursing Home Other Expenses	Other Expenses		Nursing Home Total	Other Total
Dietary	1	255,797	495,832	-	-	495,832	Meals Served	48,516	81,516	152,243	103,554	142,862	97,173	-	295,105	200,727
Food	2	-	243,878	-	-	243,878	Meals Served	48,516	81,516	-	-	145,149	98,729	-	145,149	98,729
Housekeeping	3	150,829	174,297	-	-	174,297	Square Feet (1)	46,408	93,475	74,883	75,946	11,651	11,817	-	86,534	87,763
Laundry	4	30,713	45,849	-	-	45,849	Patient Days (1)	16,172	27,172	18,280	12,433	9,009	6,127	-	27,288	18,561
Heat and Other Utilities	5	-	227,641	-	-	227,641	Square Feet	46,408	93,475	-	-	113,018	114,623	-	113,018	114,623
Maintenance	6	81,154	198,505	-	9,776	188,729	Square Feet	46,408	93,475	40,291	40,863	63,184	54,167	-	103,475	95,030
Other	7	-	-	-	-	-	Patient Days	46,408	93,475	-	-	-	-	-	-	-
Medical Director	9	-	12,000	-	12,000	-	Direct Staffing	1,450,872	1,965,844	-	-	12,000	-	-	12,000	-
Nursing and Medical Records	10	1,692,464	1,777,793	1,450,872	70,427	256,494	Direct Staffing	1,450,872	1,965,844	1,629,177	63,287	81,425	3,904	-	1,710,602	67,191
Therapy	10a	82,975	84,544	82,975	1,569	-	Direct Staffing	1,450,872	1,965,844	82,975	-	1,569	-	-	84,544	-
Activities	11	73,852	81,675	28,257	-	53,418	Patient Days (2)	16,172	27,172	55,394	18,458	4,656	3,167	-	60,050	21,625
Social Services	12	120,998	84,500	-	-	84,500	Patient Days (3)	16,172	27,172	72,015	48,983	(21,723)	(14,775)	-	50,292	34,208
CNA Training	13	-	-	-	-	-	Direct	-	-	-	-	-	-	-	-	-
Transportation	14	-	-	-	-	-	Patient Days (4)	16,172	27,172	-	-	-	-	-	-	-
Other	15	-	-	-	-	-	Patient Days (4)	16,172	27,172	-	-	-	-	-	-	-
Administrative	17	120,098	481,780	-	-	481,780	Net Patient Revenue	6,062,684	8,212,839	88,656	31,442	266,992	94,690	-	355,648	126,132
Directors Fees	18	-	-	-	-	-	N/A	-	-	-	-	-	-	-	-	-
Professional Fees	19	-	24,839	-	-	24,839	Net Patient Revenue	6,062,684	8,212,839	-	-	18,336	6,503	-	18,336	6,503
Dues and Subscriptions	20	-	25,770	-	741	25,030	Net Patient Revenue	6,062,684	8,212,839	-	-	19,217	6,553	-	19,217	6,553
Office and Clerical	21	232,989	298,478	-	1,599	296,880	Net Patient Revenue	6,062,684	8,212,839	171,992	60,997	48,762	16,727	-	220,754	77,724
Employee Benefits	22	-	835,688	-	-	835,688	Allocated Salary	2,385,903	3,442,024	-	-	579,273	256,415	-	579,273	256,415
Inservice Training and Expense	23	-	6,463	-	-	6,463	Patient Days	16,172	27,172	-	-	3,847	2,616	-	3,847	2,616
Travel and Seminar	24	-	3,797	-	2,497	1,300	Patient Days	16,172	27,172	-	-	3,271	526	-	3,271	526
Other Staff Transportation	25	-	1,159	-	-	1,159	Patient Days	16,172	27,172	-	-	690	469	-	690	469
Insurance	26	-	133,106	-	-	133,106	Net Revenue	6,062,684	8,212,839	-	-	98,258	34,848	-	98,258	34,848
Other	27	-	-	-	-	-	N/A	-	-	-	-	-	-	-	-	-
Depreciation	30	-	836,569	-	-	836,569	Square Feet	46,408	93,475	-	-	415,336	421,233	-	415,336	421,233
Amortization	31	-	-	-	-	-	Net Patient Revenue	46,408	93,475	-	-	-	-	-	-	-
Interest	32	-	860,480	-	-	860,480	Square Feet	46,408	93,475	-	-	427,207	433,273	-	427,207	433,273
Real Estate Taxes	33	-	-	-	-	-	Square Feet	46,408	93,475	-	-	-	-	-	-	-
Rent - Facilities and Grounds	34	-	-	-	-	-	N/A	-	-	-	-	-	-	-	-	-
Rent - Equipment and Vehicles	35	-	33,496	-	10,451	23,045	Patient Days	16,172	27,172	-	-	24,167	9,329	-	24,167	9,329
Other	36	-	-	-	-	-	N/A	-	-	-	-	-	-	-	-	-
Medically Necessary Transportation	38	-	-	-	-	-	N/A	-	-	-	-	-	-	-	-	-
Ancillary Service Centers	39	-	969,014	-	-	969,014	Direct	1	1	-	-	969,014	-	-	969,014	-
Barber and Beauty Shop	40	-	-	-	-	-	Direct	-	-	-	-	-	-	-	-	-
Coffee and Gift Shops	41	-	-	-	-	-	Direct	-	-	-	-	-	-	-	-	-
Provider Participation Fee	42	-	90,860	-	-	90,860	Direct	1	1	-	-	90,860	-	-	90,860	-
Other	43	600,155	-	-	-	-	Direct	-	1	-	600,155	-	(600,155)	-	-	-
		<u>3,442,024</u>	<u>8,028,013</u>	<u>1,562,103</u>	<u>109,059</u>	<u>6,356,850</u>				<u>2,385,903</u>	<u>1,056,121</u>	<u>3,528,030</u>	<u>1,057,959</u>	<u>-</u>	<u>5,913,934</u>	<u>2,114,079</u>

STATE OF ILLINOIS

Summary A

Facility Name & ID Number St Joseph Village of Chicago# 0046581

Report Period Beginning:

07/01/13

Ending:

06/30/14

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	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
		(to Sch V, col.7)												
1	Dietary	(200,727)	0	0	0	0	0	0	0	0	0	0	(200,727)	1
2	Food Purchase	(111,491)	0	0	0	0	0	0	0	0	0	0	(111,491)	2
3	Housekeeping	(87,763)	0	0	0	0	0	0	0	0	0	0	(87,763)	3
4	Laundry	(18,561)	0	0	0	0	0	0	0	0	0	0	(18,561)	4
5	Heat and Other Utilities	(118,913)	0	0	0	0	0	0	0	0	0	0	(118,913)	5
6	Maintenance	(97,320)	0	0	0	0	0	0	0	0	0	0	(97,320)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(634,774)	0	0	0	0	0	0	0	0	0	0	(634,774)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(67,803)	0	0	0	0	0	0	0	0	0	0	(67,803)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(22,820)	0	0	0	0	0	0	0	0	0	0	(22,820)	11
12	Social Services	(100,486)	0	0	0	0	0	0	0	0	0	0	(100,486)	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(1,094)	0	0	0	0	0	0	0	0	0	0	(1,094)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(192,204)	0	0	0	0	0	0	0	0	0	0	(192,204)	16
	C. General Administration													
17	Administrative	(126,132)	(166,386)	0	0	0	0	0	0	0	0	0	(292,518)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(21,759)	0	0	0	0	0	0	0	0	0	0	(21,759)	19
20	Fees, Subscriptions & Promotions	(8,203)	0	0	0	0	0	0	0	0	0	0	(8,203)	20
21	Clerical & General Office Expenses	(127,498)	0	0	0	0	0	0	0	0	0	0	(127,498)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	(2,616)	0	0	0	0	0	0	0	0	0	0	(2,616)	23
24	Travel and Seminar	(1,655)	0	0	0	0	0	0	0	0	0	0	(1,655)	24
25	Other Admin. Staff Transportation	(469)	0	0	0	0	0	0	0	0	0	0	(469)	25
26	Insurance-Prop.Liab.Malpractice	(34,848)	0	0	0	0	0	0	0	0	0	0	(34,848)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(323,180)	(166,386)	0	(489,566)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(1,150,158)	(166,386)	0	(1,316,544)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number St Joseph Village of Chicago

0046581

Report Period Beginning:

07/01/13

Ending:

06/30/14

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS
													(to Sch V, col.7)
30	Depreciation	(421,233)	0	0	0	0	0	0	0	0	0	0	(421,233) 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	(437,123)	0	0	0	0	0	0	0	0	0	0	(437,123) 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	(9,329)	0	0	0	0	0	0	0	0	0	0	(9,329) 35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 36
37	TOTAL Ownership	(867,686)	0	0	0	0	0	0	0	0	0	0	(867,686) 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	(23,326)	0	0	0	0	0	0	0	0	0	0	(23,326) 40
41	Coffee and Gift Shops	(592)	0	0	0	0	0	0	0	0	0	0	(592) 41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0 42
43	Other (specify):*	(724,724)	0	0	0	0	0	0	0	0	0	0	(724,724) 43
44	TOTAL Special Cost Centers	(748,642)	0	0	0	0	0	0	0	0	0	0	(748,642) 44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(2,766,486)	(166,386)	0	(2,932,872) 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
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 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	17 FSCSC Shared Expenses	\$ 528,068	Franciscan Sisters of Chicago Service Corporation	100.00%	\$ 361,682	\$	(166,386)	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		\$ 528,068			\$ 361,682	\$ *	(166,386)	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:

07/01/13

Ending:

06/30/14

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.	100%	St. Joseph Village of Chicago	Chicago, IL	Franciscan Sisters	Lemont, IL	Religious Cong.	1
2					of Chicago			2
3			The Village at Victory Lakes	Lindenhurst, IL				3
4	Board of Directors & Officers				Franciscan Sisters of			4
5			Addolorata Villa	Wheeling, IL	Chicago Serv Corp	Homewood, IL	Corp. Management	5
6	Sister M. Francis Clare Radke							6
7	Annette Shoemaker		Franciscan Village	Lemont, IL	St. James			7
8	Judy Amiano				Senior Estates	Crete, IL	Ind. Living	8
9	Sandra Singer		St. Anthony Home	Crown Point, IN				9
10	Ronald Tinsley				Marian Village	Homer Glen, IL	Ind. & Asst. Living	10
11	Tracy Shearer		University Place	West Lafayette, IN				11
12	Denise Boudreau				Franciscan			12
13			Mount Alverna Village	Parma, OH	Senior Estates	Louisville, KY	Ind. Living	13
14								14
15					Franciscan Comm.			15
16					Based Services	Michigan City, IN	Hm. Care / Hospice	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: 07/01/13 Ending: 06/30/14

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	Judy Amiano	Board Member	CEO	0.00%	See Supplemental	2.48	6.20%	Alloc. Salary	\$ 12,402	17 - 03	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 12,402		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:

07/01/13

Ending: 06/30/14

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

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

Name of Related Organization Franciscan Sisters of Chicago Serv Corp
 Street Address 1055 West 175th Street, Suite 202
 City / State / Zip Code Homewood, Illinois 60430
 Phone Number ()
 Fax Number ()

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	17	FSCSC Shared Expenses	Management Fees	8,515,708	13	\$ 6,474,687	\$ 3,777,432	528,068	\$ 401,502	1
2	17	FSCSC Shared Expenses	Health Insurance	9,478,129	13	(976,685)	0	386,432	(39,820)	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					\$ 5,498,002	\$ 3,777,432		\$ 361,682	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	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	Facility Acquisition	Varies	06/01/07	\$ 3,060,000	\$ 3,060,000		7.40%	\$ 170,204	1								
2	Amalgamated Bank		X	Facility Acquisition	Varies	03/13/13	9,664,936	9,498,929	05/01/47	4.86%	528,353	2								
3	Huntington Bank		X	Facility Acquisition	Varies	03/13/13	1,240,627	1,209,716	05/15/43	Variable	67,287	3								
4	Huntington Bank		X	Facility Acquisition	Varies	03/17/13	1,819,992	1,770,604	05/15/43	Variable	98,486	4								
5												5								
Working Capital																				
6												6								
7												7								
8												8								
9	TOTAL Facility Related						\$ 15,785,555	\$ 15,539,249			\$ 864,330	9								
B. Non-Facility Related*																				
10	Interest Income										(3,850)	10								
11												11								
12	Allocation - IL / AL										(433,273)	12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$ (437,123)	14								
15	TOTALS (line 9+line14)						\$ 15,785,555	\$ 15,539,249			\$ 427,207	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 0 Line # N/A

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

** 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:

07/01/13

Ending:

06/30/14

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2013 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 2014 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:	2009	8	
	2010	9	
	2011	10	
	2012	11	
	2013	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 2013	\$	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.

Facility Name & ID Number St Joseph Village of Chicago

0046581

Report Period Beginning:

07/01/13 Ending:

06/30/14

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 46,408 B. General Construction Type: Exterior Brick Frame Steel 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).

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 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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>		<u>2003</u>	<u>\$ 141,036</u>	1
2					2
3	TOTALS			\$ 141,036	3

Facility Name & ID Number St Joseph Village of Chicago

0046581

Report Period Beginning:

07/01/13

Ending:

06/30/14

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	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	Fire Alarm Devices (TC = \$3,485)		2012		1,936						13
14	Sprinkler Heads - Installation (TC = \$4,175)		2012		2,319						14
15	Signal Switches & Delayed Egress Maglocks - Front Entrance		2012		3,524						15
16	Signage With LED Message - Exterior Main (TC = \$11,380)		2012		6,259						16
17	One Card Reader - Installation (TC = \$2,825)		2013		2,825						17
18											18
19	Current Year Additions - FY 2013 - 2014										19
20	See CY FA Addition Schedule - Allocations and Locations										20
21											21
22	Door Closures and Locks - Hallways (TC = \$7,404)		2013		7,404						22
23	Nurse Workstations - 3rd Floor (TC = \$5,875)		2014		5,875						23
24	Entrance Sign and Lighting - Main Entrance (TC = \$14,555)		2014		7,226						24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number St Joseph Village of Chicago

0046581

Report Period Beginning:

07/01/13

Ending:

06/30/14

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69					415,336		4,276,569	69
70		\$ 9,933,940	\$ 415,336		\$ 415,336	\$	\$ 4,276,569	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	\$ 634,318	\$	\$	\$		\$	71
72	Current Year Purchases	21,456						72
73	Fully Depreciated Assets							73
74	Disposals							74
75	TOTALS	\$ 655,774	\$	\$	\$		\$	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	Bus	2007	\$ 22,893	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$ 22,893	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 10,753,643	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 415,336	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 415,336	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)	\$ 4,276,569	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Non-Care Assets - PY Total	\$ 10,871,098	\$	\$	86
87	Non-Care Assets - CY LIMP Add.	7,329			87
88	Non-Care Assets - CY EQIP Add.	9,949			88
89	Non-Care Assets - CY Disposals				89
90	Financial Statement Depreciation		421,233	4,337,288	90
91	TOTALS	\$ 10,888,376	\$ 421,233	\$ 4,337,288	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
Fixed Asset Analysis - Additions
FYE June 30, 2014

G/L Number	Cost Report Classification	Description	Page	Section	Grouping	Cost	In Service Date	Class	Method	Cost					
										46,408	47,067	46,408	47,067	93,475	
										Nursing Home	Other	Expensed - NH	Expensed - NA	Total	
Leasehold Improvements															
3-0100	Buildings - General	Phillip Patti - 3rd Floor Workstations	12	XI - B	1	4,075	04/03/14	LIMP	Direct SKU	4,075	-	-	-	4,075	
4-0100	Building Equipment	Phillip Patti - 3rd Floor Workstations	12	XI - B	1	1,800	08/13/13	LIMP	Direct SKU	1,800	-	-	-	1,800	
						<u>5,875</u>									<u>5,875</u>
4-0100	Building Equipment	Jaeger Electric - Signage Lighting	12	XI - B	2	850	03/04/14	LIMP	Indirect	422	428	-	-	850	
4-0100	Building Equipment	Landmark Sign - Exterior Main Signage	12	XI - B	2	12,405	02/25/14	LIMP	Indirect	6,159	6,246	-	-	12,405	
4-0100	Building Equipment	Jaeger Electric - Exterior Signage	12	XI - B	2	1,300	02/26/14	LIMP	Indirect	645	655	-	-	1,300	
						<u>14,555</u>									<u>14,555</u>
4-0100	Building Equipment	Red Hawk - Door Closure	12	XI - B	3	1,679	12/23/13	LIMP	Direct SKU	1,679	-	-	-	1,679	
4-0100	Building Equipment	Fox Valley - Automatic Door Closers	12	XI - B	3	3,350	08/30/13	LIMP	Direct SKU	3,350	-	-	-	3,350	
4-0100	Building Equipment	Fox Valley - Door / Keylock	12	XI - B	3	2,375	09/27/13	LIMP	Direct SKU	2,375	-	-	-	2,375	
						<u>7,404</u>									<u>7,404</u>
4-0100	Building Equipment	Grainger - 14 2 CU Chminum MC 100'			EXP	79	02/26/14	LIMP	Direct SKU	-	-	79	-	79	
4-0100	Building Equipment	Grainger - Tile Adhesive			EXP	27	02/25/14	LIMP	Direct SKU	-	-	27	-	27	
4-0100	Building Equipment	Grainger - Wall Plates			EXP	122	02/21/14	LIMP	Direct SKU	-	-	122	-	122	
4-0100	Building Equipment	Jaeger Electric - Chapel Ceiling Fans			EXP	1,610	02/27/14	LIMP	Indirect	-	-	799	811	1,610	
4-0100	Building Equipment	Sherpa Consulting - AL Carpet			EXP	1,308	05/04/14	LIMP	Direct ALU	-	-	-	1,308	1,308	
						<u>3,146</u>									<u>3,146</u>
Sub - Total						30,980									30,980
										20,505	7,329	1,027	2,118	30,980	
Equipment															
5-0100	Moveable Equipment	ABT Electronics - Washer and Dryer			1	2,100	07/14/13	EQUIP	Direct ALU	-	2,100	-	-	2,100	
5-0100	Moveable Equipment	Grainger - Additional Wiring Washer and Dryer			1	474	07/25/13	EQUIP	Direct ALU	-	474	-	-	474	
5-0100	Moveable Equipment	Grainger - Additional Wiring Washer and Dryer			1	173	07/02/13	EQUIP	Direct ALU	-	173	-	-	173	
						<u>2,747</u>									<u>2,747</u>
5-0100	Moveable Equipment	IT Savvy - Xtra Meraki Equipment			2	414	12/01/13	EQUIP	Indirect	206	208	-	-	414	
5-0100	Moveable Equipment	IT Savvy - Tablets			2	951	03/14/14	EQUIP	Direct SKU	951	-	-	-	951	
5-0100	Moveable Equipment	DocuSign - Business Editions Seats			2	1,294	03/25/14	EQUIP	Direct SKU	1,294	-	-	-	1,294	
5-0100	Moveable Equipment	IT Savvy - Stylus			2	15	04/21/14	EQUIP	Indirect	7	8	-	-	15	
5-0100	Moveable Equipment	MNJ Technologies - Tablet			2	467	04/08/14	EQUIP	Direct SKU	467	-	-	-	467	
5-0100	Moveable Equipment	Network Hardware - Domain Controllers			2	2,467	01/23/14	EQUIP	Indirect	1,225	1,242	-	-	2,467	
						<u>5,608</u>									<u>5,608</u>
5-0100	Moveable Equipment	Brothers Furniture - Chair Reupholster			3	3,565	01/17/14	EQUIP	Direct SKU	3,565	-	-	-	3,565	
5-0100	Moveable Equipment	Brothers Furniture - Chair Reupholster			3	3,085	06/05/14	EQUIP	Direct SKU	3,085	-	-	-	3,085	
						<u>6,650</u>									<u>6,650</u>
5-0100	Moveable Equipment	Michael J Barr - Patio Furniture			4	5,704	07/01/13	EQUIP	Indirect	2,832	2,872	-	-	5,704	
5-0100	Moveable Equipment	Michael J Barr - Patio Furniture			4	5,704	07/01/13	EQUIP	Indirect	2,832	2,872	-	-	5,704	
						<u>11,408</u>									<u>11,408</u>
5-0100	Moveable Equipment	Professional Medical - Test Meter			5	4,993	07/01/13	EQUIP	Direct SKU	4,993	-	-	-	4,993	
						<u>4,993</u>									<u>4,993</u>
5-0100	Moveable Equipment	Airdstrutor - Chapel Ceiling Fans			EXP	514	02/12/14	EQUIP	Indirect	-	-	255	259	514	
5-0100	Moveable Equipment	The Room Place - Bed			EXP	1,499	04/15/14	EQUIP	Direct SKU	-	-	1,499	-	1,499	
5-0100	Moveable Equipment	Sears - Lawn Mower			EXP	1,567	05/13/14	EQUIP	Indirect	-	-	778	789	1,567	
						<u>3,580</u>									<u>3,580</u>
Sub - Total						34,980									34,980
										21,450	9,949	2,532	1,048	34,980	
Total						65,965									65,965
										41,901	17,278	3,560	3,106	65,965	

Facility Name & ID Number St Joseph Village of Chicago

0046581

Report Period Beginning: 07/01/13

Ending: 06/30/14

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions.

YES NO

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

**

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

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

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

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: \$ 24,167 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

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.	_____ /2015	\$ _____
13.	_____ /2016	\$ _____
14.	_____ /2017	\$ _____

* 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
Medicaid Cost Report
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Page 14 Supplemental Schedule - Building and Fixed Equipment

Vendor	Amount
Total	-

Page 14 Supplemental Schedule - Equipment Rental

Vendor	Item Rented	Amount
Unidine	Dietary Equipment	1,465
GE Capital	Copier	6,908
Pitney Bowes	Postage Machine	512
Accelerated Care Plus	Therapy Equipment	14,160
Unlimited Advacare, Inc.	Medical Equipment	10,451
Allocation - IL / AL		(9,329)
Total		24,167

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?</p> <p><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>2. CLASSROOM PORTION:</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. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3		4		6 Supplies (Actual or) Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Staff		Outside Practitioner (other than consultant)							
			Units of Service	Cost	Units	Cost						
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$	228,008	\$		\$	228,008	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				80,641				80,641	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39 - 03	hrs				304,125				304,125	4
5	Physician Care		visits									5
6	Dental Care		visits									6
7	Work Related Program		hrs									7
8	Habilitation		hrs									8
9	Pharmacy	39 - 02	# of prescripts					256,476			256,476	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Other (specify): See Supplemental	39 - 02						69,365			69,365	12
13	Other (specify): See Supplemental	39 - 03					30,400				30,400	13
14	TOTAL			\$		\$	643,173	\$	325,841	\$	969,014	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
Medicaid Cost Report
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Page 16 Supplemental Schedule

Description	Supplies	Other
Oxygen and Supplies	16,947	
Medical Supplies	52,418	
Respiratory Therapy		5,197
Radiology		6,605
Laboratory		7,378
Transportation		11,220
Total	69,365	30,400

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/14

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 402	\$	1
2	Cash-Patient Deposits	4,179		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>146,000</u>)	742,697		3
4	Supply Inventory (priced at <u>Cost - FIFO</u>)	32,206		4
5	Short-Term Investments			5
6	Prepaid Insurance	1,317		6
7	Other Prepaid Expenses	51,125		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Supplemental Schedule</u>			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 831,926	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	1,331,889		13
14	Buildings, at Historical Cost	15,073,131		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	4,931,167		16
17	Accumulated Depreciation (book methods)	(8,613,857)		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): <u>See Supplemental Schedule</u>			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 12,722,330	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 13,554,256	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 441,702	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	4,179		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	252,525		30
31	Accrued Taxes Payable (excluding real estate taxes)	1,384		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Supplemental Schedule</u>	110,015		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 809,805	\$	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	<u>See Supplemental Schedule</u>			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 809,805	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 12,744,451	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 13,554,256	\$	48

*(See instructions.)

**St Joseph Village of Chicago
Medicaid Cost Report
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Page 17 Supplemental Schedule

Description	Operating	After Consolidation
Line 9 - Other Current Assets		
Total	-	-
Line 23 - Other Long Term Assets		
Total	-	-
Line 36 - Other Current Liabilities		
Reservation Deposits	4,000	
Refundable Deposits	79,379	
Unrefundable Deposits (Net of Amortization)	26,636	
Total	110,015	-
Line 43 - Other Long Term Liabilities		
Total	-	-

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 13,550,171	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 13,550,171	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(809,723)	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)	\$ (809,723)	17
B. Transfers (Itemize):			
18	Temporarily Restricted Net Assets Released	4,003	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 4,003	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 12,744,451	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

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 7,927,926	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,927,926	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	148,877	6
7	Oxygen	2,489	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 151,366	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	10,770	12
13	Barber and Beauty Care	27,431	13
14	Non-Patient Meals	2,584	14
15	Telephone, Television and Radio	12,138	15
16	Rental of Facility Space	5,425	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	5	19
20	Radiology and X-Ray		20
21	Other Medical Services	133,541	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 191,894	23
D. Non-Operating Revenue			
24	Contributions	14,916	24
25	Interest and Other Investment Income***	3,850	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 18,766	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	3,546	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 3,546	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,293,498	30

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,405,344	31
32	Health Care	2,109,691	32
33	General Administration	2,045,275	33
B. Capital Expense			
34	Ownership	1,734,395	34
C. Ancillary Expense			
35	Special Cost Centers	1,717,656	35
36	Provider Participation Fee	90,860	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,103,221	40
41	Income before Income Taxes (line 30 minus line 40)**	(809,723)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (809,723)	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 202,896	44
45	Private Pay - Net Inpatient Revenue	4,469,799	45
46	Medicare - Net Inpatient Revenue	2,904,902	46
47	Other-(specify) <u>Insurance - Net Inpatient Revenue</u>	350,329	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 7,927,926	49

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

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

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

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

**St Joseph Village of Chicago
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Page 19 Supplemental Schedule

Description	Total	Adjustment
Line 28 - Other Revenue		
Activity Revenue	1,195	1,195
Transportation Revenue	1,299	1,299
Copy Revenue	411	411
Jury Duty Revenue	17	17
Space Rental Revenue	425	425
Other Income	200	200
Total	3,546	3,546

Facility Name & ID Number St Joseph Village of Chicago

0046581

Report Period Beginning:

07/01/13

Ending:

06/30/14

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	1,940	2,084	\$ 95,973	\$ 46.05	1
2	Assistant Director of Nursing					2
3	Registered Nurses	20,089	22,075	678,955	30.76	3
4	Licensed Practical Nurses	10,322	11,619	291,503	25.09	4
5	CNAs & Orderlies	41,220	45,999	565,630	12.30	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,278	2,488	82,975	33.35	8
9	Activity Director	1,848	2,080	45,596	21.92	9
10	Activity Assistants	2,118	2,374	28,257	11.90	10
11	Social Service Workers	3,856	4,032	120,998	30.01	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	4,965	5,304	84,434	15.92	14
15	Cook Helpers/Assistants	14,628	15,642	171,363	10.96	15
16	Dishwashers					16
17	Maintenance Workers	3,652	3,963	81,154	20.48	17
18	Housekeepers	10,826	12,015	150,829	12.55	18
19	Laundry	2,696	2,764	30,713	11.11	19
20	Administrator	1,912	2,080	120,098	57.74	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,934	14,228	232,989	16.38	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,421	1,799	19,343	10.75	31
32	Other Health Care(specify)	1,271	1,725	41,058	23.80	32
33	Other(specify) <u>See Supplemental</u>	36,591	40,360	600,156	14.87	33
34	TOTAL (lines 1 - 33)	174,567	192,631	\$ 3,442,024 *	\$ 17.87	34

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			35
36	Medical Director	12,000	09 - 03	36
37	Medical Records Consultant	2,861	10 - 03	37
38	Nurse Consultant	13,352	10 - 03	38
39	Pharmacist Consultant	3,058	10 - 03	39
40	Physical Therapy Consultant	754	10a - 03	40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant	810	11 - 03	44
45	Social Service Consultant			45
46	Other(specify)			46
47	<u>Dietary Management</u>	198,392	01 - 03	47
48	<u>Priests / Organist</u>	23,433	12 - 03	48
49	TOTAL (lines 35 - 48)	\$ 254,660		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

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

** See instructions.

**St Joseph Village of Chicago
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Page 20 Supplemental Schedule

Description	Hours Worked	Hours Paid	Salary
Other Salaries			
Assisted Living (Line 43)	34,751	38,388	539,416
Marketing (Line 43)	1,840	1,972	60,740
Total	<u>36,591</u>	<u>40,360</u>	<u>600,156</u>

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		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2	N/A											
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

