

		FOR BHF USE					

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2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: <u>0027045</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																																	
Facility Name: <u>St. Joseph's Home For The Elderly</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2011</u> to <u>12/31/2011</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																																																	
Address: <u>80 West Northwest Highway</u> <u>Palatine</u> <u>60067</u>																																																			
Number City Zip Code																																																			
County: <u>Cook</u>																																																			
Telephone Number: <u>(847) 358-5700</u> Fax # <u>(847) 358-5719</u>																																																			
HFS ID Number: _____																																																			
Date of Initial License for Current Owners: <u>01/09/1967</u>																																																			
Type of Ownership:																																																			
<table><tr><td>☒</td><td>VOLUNTARY, NON-PROFIT</td><td>☐</td><td>PROPRIETARY</td><td>☐</td><td>GOVERNMENTAL</td></tr><tr><td>☒</td><td>Charitable Corp.</td><td>☐</td><td>Individual</td><td>☐</td><td>State</td></tr><tr><td>☐</td><td>Trust</td><td>☐</td><td>Partnership</td><td>☐</td><td>County</td></tr><tr><td></td><td></td><td>☐</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td></td><td></td><td>☐</td><td>"Sub-S" Corp.</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Limited Liability Co.</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Trust</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Other _____</td><td></td><td></td></tr></table>		☒	VOLUNTARY, NON-PROFIT	☐	PROPRIETARY	☐	GOVERNMENTAL	☒	Charitable Corp.	☐	Individual	☐	State	☐	Trust	☐	Partnership	☐	County			☐	Corporation	☐	Other _____			☐	"Sub-S" Corp.					☐	Limited Liability Co.					☐	Trust					☐	Other _____				
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		☐	Trust																																																
		☐	Other _____																																																
IRS Exemption Code <u>501c3</u>																																																			
In the event there are further questions about this report, please contact:																																																			
Name: <u>Mother Marguerite McCarthy</u>																																																			
Telephone Number: <u>(847) 358-5700</u>																																																			
Email Address: _____																																																			
		<table><tr><td rowspan="2">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Date) <u>04/30/2012</u></td></tr><tr><td rowspan="5">Paid Preparer</td><td>(Type or Print Name) <u>Mother Marguerite McCarthy</u></td></tr><tr><td>(Title) <u>President</u></td></tr><tr><td>(Signed) _____</td></tr><tr><td>(Date) <u>04/30/2012</u></td></tr><tr><td>(Print Name and Title) <u>Elizabeth Vaccariello</u> <u>Vice President</u></td></tr><tr><td></td><td>(Firm Name & Address) <u>Varey & Vaccariello CPAs PC</u> <u>617 E. Golf Road, Suite 107, Arlington Heights, IL 60005</u></td></tr><tr><td></td><td>(Telephone) <u>(847) 228-6977</u> Fax # <u>(847) 228-0317</u></td></tr><tr><td colspan="2"></td><td colspan="2"> MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630 </td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Date) <u>04/30/2012</u>	Paid Preparer	(Type or Print Name) <u>Mother Marguerite McCarthy</u>	(Title) <u>President</u>	(Signed) _____	(Date) <u>04/30/2012</u>	(Print Name and Title) <u>Elizabeth Vaccariello</u> <u>Vice President</u>		(Firm Name & Address) <u>Varey & Vaccariello CPAs PC</u> <u>617 E. Golf Road, Suite 107, Arlington Heights, IL 60005</u>		(Telephone) <u>(847) 228-6977</u> Fax # <u>(847) 228-0317</u>			MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630																																
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Facility Name & ID Number St. Joseph's Home For The Elderly

0027045 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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 11/14/2011

	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>7,300</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>40</u>	Intermediate (ICF)	<u>39</u>	<u>14,552</u>	3
4		Intermediate/DD			4
5	<u>7</u>	Sheltered Care (SC)	<u>7</u>	<u>2,555</u>	5
6		ICF/DD 16 or Less			6
7	<u>67</u>	TOTALS	<u>66</u>	<u>24,407</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	Total	
8	SNF					8
9	SNF/PED					9
10	ICF	<u>19,108</u>	<u>1,874</u>		<u>20,982</u>	10
11	ICF/DD					11
12	SC		<u>2,190</u>		<u>2,190</u>	12
13	DD 16 OR LESS					13
14	TOTALS	<u>19,108</u>	<u>4,064</u>		<u>23,172</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.94%

D. How many bed-hold days during this year were paid by the Department? 111 (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

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/2011 Fiscal Year: 13/31/2011
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number St. Joseph's Home For The Elderly # 0027045 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	377,533	8,348	87,847	473,728		473,728	(64,757)	408,971			1
2	Food Purchase		117,003		117,003		117,003		117,003			2
3	Housekeeping		24,840	252,360	277,200		277,200		277,200			3
4	Laundry	80,529	29,370		109,899		109,899	(7,686)	102,213			4
5	Heat and Other Utilities			330,185	330,185		330,185	(128,309)	201,876			5
6	Maintenance	159,138	84,489	128,138	371,765		371,765	(8,847)	362,918			6
7	Other (specify):*	62,190		14,209	76,399		76,399		76,399			7
8	TOTAL General Services	679,390	264,050	812,739	1,756,179		1,756,179	(209,599)	1,546,580			8
	B. Health Care and Programs											
9	Medical Director			2,200	2,200		2,200		2,200			9
10	Nursing and Medical Records	1,850,499	74,484	166,149	2,091,132		2,091,132		2,091,132			10
10a	Therapy	73,115			73,115		73,115		73,115			10a
11	Activities	110,827	38,042	1,900	150,769		150,769		150,769			11
12	Social Services	25,333		800	26,133		26,133		26,133			12
13	CNA Training											13
14	Program Transportation			5,610	5,610		5,610		5,610			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,059,774	112,526	176,659	2,348,959		2,348,959		2,348,959			16
	C. General Administration											
17	Administrative			82,021	82,021		82,021		82,021			17
18	Directors Fees											18
19	Professional Services			60,178	60,178		60,178		60,178			19
20	Dues, Fees, Subscriptions & Promotions			69,142	69,142		69,142	(53,232)	15,910			20
21	Clerical & General Office Expenses	273,327	36,363	139,267	448,957		448,957		448,957			21
22	Employee Benefits & Payroll Taxes			660,452	660,452		660,452		660,452			22
23	Inservice Training & Education			5,119	5,119		5,119		5,119			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			16,830	16,830		16,830		16,830			25
26	Insurance-Prop.Liab.Malpractice			42,302	42,302		42,302	(6,806)	35,496			26
27	Other (specify):* Bad Debts			41,432	41,432		41,432	(41,432)				27
28	TOTAL General Administration	273,327	36,363	1,116,743	1,426,433		1,426,433	(101,470)	1,324,963			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,012,491	412,939	2,106,141	5,531,571		5,531,571	(311,069)	5,220,502			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	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			395,764	395,764		395,764	(48,154)	347,610			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	TOTAL Ownership			395,764	395,764		395,764	(48,154)	347,610			37
	Ancillary Expense											
	E. Special Cost Centers											
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			32,850	32,850		32,850		32,850			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			32,850	32,850		32,850		32,850			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,012,491	412,939	2,534,755	5,960,185		5,960,185	(359,223)	5,600,962			45

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

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(64,757)	1		4
5	Telephone, TV & Radio in Resident Rooms	(5,358)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(7,686)	4		8
9	Non-Straightline Depreciation	(48,154)	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	(122,951)	5		15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(8,847)	6		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance	(6,806)	26		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(41,432)	27		24
25	Fund Raising, Advertising and Promotional	(53,232)	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	SUBTOTAL (A): (Sum of lines 1-29)	\$ (359,223)		\$	30

BHF USE ONLY								
48		49		50		51		52

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (359,223)		37

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

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

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		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	TOTAL (C): (sum of lines 38-46)			\$		47

Report Period Beginning:

Ending:

ID#0027045

01/01/2011

12/31/2011

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
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
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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	Total	0		49

Summary A

12/31/2011

[illegible]

Summary B

12/31/2011

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

[illegible]

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 -		Little Sisters of the Poor - Chicago		
		St. Mary's Home	Chicago, IL	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	\$ 14,906	Little Sisters of the Poor - Chicago Province, Inc.	0.00%	\$ 14,906	\$	1
2	V	19	Corporate Compliance	4,778	Little Sisters of the Poor - Chicago Province, Inc.	0.00%	4,778		2
3	V	19	Computer Consulting - IT	5,511	Little Sisters of the Poor - Chicago Province, Inc.	0.00%	5,511		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			\$ 25,195			\$ 25,195	\$ *	14

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

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
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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. Joseph's Home For The Elderly # 0027045 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

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 N/A
Street Address _____
City / State / Zip Code _____
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						\$	\$			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

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	Little Sisters of the Poor						\$					\$	1
2	- Chicago Province, Inc.	X		Construction	NONE	Various	2,265,570	2,265,570	Various	0.0300			2
3													3
4													4
5													5
	Working Capital												
6	Little Sisters of the Poor												6
7	- Chicago Province, Inc.	X		Working Capital	NONE	Various	3,440,310	3,440,310	Various	0.0300			7
8													8
9	TOTAL Facility Related						\$ 5,705,880	\$ 5,705,880				\$	9
	B. Non-Facility Related*												
10	Little Sisters of the Poor												10
11	- Chicago Province, Inc.	X		Convent Allocation	NONE	Various	1,094,120	1,094,120	Various	0.0300			11
12													12
13													13
14	TOTAL Non-Facility Related						\$ 1,094,120	\$ 1,094,120				\$	14
15	TOTALS (line 9+line14)						\$ 6,800,000	\$ 6,800,000				\$	15

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

[illegible]

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	<u>St. Joseph's Home For The Elderly</u>	COUNTY	<u>Cook</u>
FACILITY IDPH LICENSE NUMBER	<u>0027045</u>		
CONTACT PERSON REGARDING THIS REPORT	<u>Mother Marguerite McCarthy</u>		
TELEPHONE	<u>(847) 358-5700</u>	FAX #:	<u>(847) 358-5719</u>

Enter the tax index number and real estate tax assessed for 2010 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 2010.

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 Sisters 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: N/A
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>Existing Structure</u>	<u>653,400</u>	<u>1966</u>	<u>\$ 76,284</u>	1
2					2
3	TOTALS	653,400		\$ 76,284	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
	Improvement Type**										
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	242	40		(242)	40,716	12
13	Health Related Renovation			1971	22,307	665	40	322	(343)	22,307	13
14	Health Related Renovation			1972	119,419	3,558	40	2,986	(572)	119,413	14
15	Health Related Renovation			1974	10,272	306	40	257	(49)	9,845	15
16	Health Related Renovation			1975	9,671	288	40	242	(46)	9,075	16
17	Health Related Renovation			1976	965	29	40	24	(5)	883	17
18	Health Related Renovation			1978	44,279	1,319	40	1,107	(212)	38,316	18
19	Interior Renovation - Conversion from Wards to Rooms			1983	3,663,633	109,154	40	91,591	(17,563)	2,676,825	19
20	New Fire Door System			1984	25,217	751	40	630	(121)	17,576	20
21	Complete Boiler Renovation			1985	470,291	14,012	40	11,757	(2,255)	315,717	21
22	Electrical Repairs & New Cooling System for Boilers			1987	106,618	3,177	40	2,666	(511)	66,059	22
23	Concrete Restoration			1990	111,172	3,312	40	2,779	(533)	60,315	23
24	Exterior Renovation Including New Windows			1991	317,750	9,467	40	7,944	(1,523)	164,112	24
25	Driveway Restored			1991	32,334		10			32,334	25
26	Sewer Renovation			1992	13,999	417	40	350	(67)	6,858	26
27	Asbestos Removal & Central Air Conditioning			1992	1,051,235	31,320	40	26,281	(5,039)	524,497	27
28	Remodel Center & West Wings			1993	2,619,173	78,035	40	65,479	(12,556)	1,205,786	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)	2,622	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's Home For The Elderly

0027045

Report Period Beginning:

01/01/2011 Ending: 12/31/2011

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	
	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)	\$ 223	37
38	New Flooring	2006	1,339	40	40	34	(6)	186	38
39	Asphalt Replacement	2008	7,063	842	10	706	(136)	2,471	39
40	Garage Roof	2009	13,039	388	40	326	(62)	815	40
41	Parking Lot Lights and Poles	2009	35,825	2,135	20	1,791	(344)	4,478	41
42	Concrete and Curb Replacement	2009	15,752	1,877	10	1,575	(302)	3,938	42
43	Building Roof Replacement	2011	757,126	11,279	40	9,464	(1,815)	9,464	43
44									44
45									45
46									46
47									47
48									48
49									49
50	2006 Cap Bldg Repairs - Elevator Motor Repair	2006	2,916		5	292	292	2,916	50
51	2007 Cap Bldg Repairs - Roof and Electrical Repairs	2007	17,788		5	3,558	3,558	16,011	51
52	2008 Cap Bldg Repairs - Storm Sewer Repair	2008	3,067		5	613	613	2,146	52
53	2009 Cap Bldg Repairs - Doors, Fire Alarm, HVAC and Plumbing	2009	29,121		5	5,824	5,824	14,560	53
54	2010 Cap Bldg Repairs - HVAC, Plumbing and Electric Repairs	2010	24,655		5	4,931	4,931	7,397	54
55	2011 Cap Bldg Repairs - Plumbing and HVAC Repairs	2011	7,424		5	742	742	742	55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 13,013,798	\$ 273,021		\$ 244,614	\$ (28,407)	\$ 8,810,741	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 Truct	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	2	
	Reference	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	\$ 943,951	\$ 112,537	\$ 94,430	\$ (18,107)	10 Years	\$ 491,417	71
72	Current Year Purchases	41,578	2,544	2,135	(409)	10 Years	2,135	72
73	Fully Depreciated Assets	723,740				10 Years	723,740	73
74								74
75	TOTALS	\$ 1,709,269	\$ 115,081	\$ 96,565	\$ (18,516)		\$ 1,217,292	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	3,814	3,201	(613)	4	25,605	77
78	Care Use	2008 Ford F250 Truck w/Plow	2007	25,829	3,848	3,230	(618)	4	25,829	78
79										79
80	TOTALS			\$ 181,880	\$ 7,662	\$ 6,431	\$ (1,231)		\$ 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)	\$ 14,981,231	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 395,764	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 347,610	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (48,154)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 10,209,913	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 Allo0cation Various	\$ 2,479,142	\$ 44,367	\$ 1,613,295	86
87	Equip - Convent Allocation Various	327,758	18,516	233,417	87
88	Vehicles - Convent Allocation Var	34,876	1,231	34,876	88
89					89
90					90
91	TOTALS	\$ 2,841,776	\$ 64,114	\$ 1,881,588	91

G. Construction-in-Progress

	Description	Cost	
92	Mechanical Systems Update	\$ 37,128	92
93			93
94			94
95		\$ 37,128	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.

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	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: \$ _____ 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	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.	/2012	\$
13.	/2013	\$
14.	/2014	\$

* 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.

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

* ALL AIDES EMPLOYED HAVE PREVIOUSLY OBTAINED THE NECESSARY TRAINING

B. EXPENSES

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	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	TOTAL			\$		\$	\$		\$	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.

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 323,918	\$	1
2	Cash-Patient Deposits	28,902		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 15,000)	683,907		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	34,853		6
7	Other Prepaid Expenses	6,029		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Legacies Receivable	347,599		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,425,208	\$	10
	B. Long-Term Assets			
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	2,253,783		16
17	Accumulated Depreciation (book methods)	(12,047,729)		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): Construction in Progress	37,128		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 5,762,538	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 7,187,746	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 96,232	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	28,902		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	124,653		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
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 249,787	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	6,800,000		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 6,800,000	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 7,049,787	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 137,959	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 7,187,746	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,674,672	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,674,672	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,536,713)	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)	\$ (1,536,713)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 137,959	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number St. Joseph's Home For The Elderly

0027045

Report Period Beginning: 01/01/2011

Ending: 12/31/2011

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.

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 2,629,710	1
2	Discounts and Allowances for all Levels	(171,638)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,458,072	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		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	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions	1,946,643	24
25	Interest and Other Investment Income***	18,757	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,965,400	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,423,472	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,756,179	31
32	Health Care	2,348,959	32
33	General Administration	1,426,433	33
	B. Capital Expense		
34	Ownership	395,764	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	32,850	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,960,185	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,536,713)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,536,713)	43

* 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.

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	1,734	2,160	71,780	33.23	2
3	Registered Nurses	15,629	16,872	482,324	28.59	3
4	Licensed Practical Nurses	12,315	13,246	340,303	25.69	4
5	CNAs & Orderlies	55,792	61,594	924,840	15.02	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,754	4,314	73,115	16.95	8
9	Activity Director	1,595	1,627	28,181	17.32	9
10	Activity Assistants	5,222	5,899	82,646	14.01	10
11	Social Service Workers	1,183	1,321	25,333	19.18	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	29,455	32,903	377,533	11.47	15
16	Dishwashers					16
17	Maintenance Workers	7,444	8,318	159,138	19.13	17
18	Housekeepers					18
19	Laundry	6,160	6,675	80,529	12.06	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,719	14,008	273,327	19.51	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	1,830	2,079	31,252	15.03	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Security Guards</u>	3,803	4,225	62,190	14.72	33
34	TOTAL (lines 1 - 33)	158,635	175,241	\$ 3,012,491 *	\$ 17.19	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	150	\$ 6,000	1 - 3	35
36	Medical Director	88	2,200	9 - 3	36
37	Medical Records Consultant	17	990	10 - 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	152	6,719	10 - 3	39
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	44
45	Social Service Consultant	16	800	12 - 3	45
46	Other(specify) <u>One Sister Acting</u>				46
47	<u>as Director of Nursing at Stipend +</u>				47
48	<u>Insurance - Room & Board</u>	2,080	41,207	10 - 3	48
49	TOTAL (lines 35 - 48)	2,519	\$ 58,716		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.

XIX. SUPPORT SCHEDULES

[illegible]

*** Attach copy of IMRF notifications**

****See instructions.**

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.

\$ 15,257

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.

\$ 32,850

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 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.