

		FOR BHF USE					

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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>0045443</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																															
Facility Name: <u>Addolorata Villa</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>07/01/15</u> to <u>06/30/16</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>555 McHenry Road</u> <u>Wheeling</u> <u>60090</u>																																																	
Number City Zip Code																																																	
County: <u>Cook</u>																																																	
Telephone Number: <u>(847) 215 - 5801</u> Fax # <u>(847) 215 - 5805</u>																																																	
HFS ID Number: _____		<table><tr><td rowspan="2">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Date) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Type or Print Name) _____</td></tr><tr><td>(Title) _____</td></tr><tr><td>(Signed) _____</td></tr><tr><td>(Date) _____</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Date) _____	Paid Preparer	(Type or Print Name) _____	(Title) _____	(Signed) _____	(Date) _____																																						
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	(Title) _____																																																
	(Signed) _____																																																
	(Date) _____																																																
Date of Initial License for Current Owners: <u>11/27/96</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 colspan="2">IRS Exemption Code <u>501(c)(3)</u></td><td>☐</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td colspan="2"></td><td>☐</td><td>"Sub-S" Corp.</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td>☐</td><td>Limited Liability Co.</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td>☐</td><td>Trust</td><td colspan="2"></td></tr><tr><td colspan="2"></td><td>☐</td><td>Other _____</td><td colspan="2"></td></tr></table>		☒	VOLUNTARY, NON-PROFIT	☐	PROPRIETARY	☐	GOVERNMENTAL	☒	Charitable Corp.	☐	Individual	☐	State	☐	Trust	☐	Partnership	☐	County	IRS Exemption Code <u>501(c)(3)</u>		☐	Corporation	☐	Other _____			☐	"Sub-S" Corp.	_____				☐	Limited Liability Co.	_____				☐	Trust					☐	Other _____		
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		☐	Trust																																														
		☐	Other _____																																														
In the event there are further questions about this report, please contact:																																																	
Name: <u>Edward N. Slack, CPA</u>		Telephone Number: <u>(847) 628 - 8796</u>																																															
Email Address: _____																																																	

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Addolorata Villa

0045443 Report Period Beginning: 07/01/15 Ending: 06/30/16

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>88</u>	Skilled (SNF)	<u>88</u>	<u>32,208</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>10</u>	Intermediate (ICF)	<u>10</u>	<u>3,660</u>	3
4		Intermediate/DD			4
5	<u>43</u>	Sheltered Care (SC)	<u>43</u>	<u>15,738</u>	5
6		ICF/DD 16 or Less			6
7	<u>141</u>	TOTALS	<u>141</u>	<u>51,606</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>5,307</u>	<u>17,621</u>	<u>4,672</u>	<u>27,600</u>	8
9	SNF/PED					9
10	ICF		<u>2,982</u>		<u>2,982</u>	10
11	ICF/DD					11
12	SC		<u>4,698</u>		<u>4,698</u>	12
13	DD 16 OR LESS					13
14	TOTALS	<u>5,307</u>	<u>25,301</u>	<u>4,672</u>	<u>35,280</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 68.36%

SEE ACCOUNTANTS' PREPARATION REPORT

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) Outpatient Therapy

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 11/27/96

J. Was the facility purchased or leased after January 1, 1978? YES ☒ Date 11/27/96 NO ☐

K. Was the facility certified for Medicare during the reporting year? YES ☒ NO ☐ If YES, enter number of beds certified 88 and days of care provided _____

Medicare Intermediary National Government Services, Inc.

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 06/30/16 Fiscal Year: 06/30/16

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

Facility Name & ID Number Addolorata Villa # 0045443 Report Period Beginning: 07/01/15 Ending: 06/30/16

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	926,081	160,063	488,099	1,574,243		1,574,243	(710,591)	863,652			1
2	Food Purchase		728,725		728,725		728,725	(325,213)	403,512			2
3	Housekeeping	468,041	77,442		545,483		545,483	(274,813)	270,670			3
4	Laundry	71,771	64,217		135,988		135,988	(58,304)	77,684			4
5	Heat and Other Utilities			549,586	549,586		549,586	(407,979)	141,607			5
6	Maintenance	458,596	76,671	641,685	1,176,952		1,176,952	(791,656)	385,296			6
7	Other (specify):* See Supplemental											7
8	TOTAL General Services	1,924,489	1,107,118	1,679,370	4,710,977		4,710,977	(2,568,556)	2,142,421			8
	B. Health Care and Programs											
9	Medical Director			25,200	25,200		25,200	(3,663)	21,537			9
10	Nursing and Medical Records	3,524,468	184,023	34,563	3,743,054		3,743,054	(80,090)	3,662,964			10
10a	Therapy	54,954	1,772	70,995	127,721		127,721	(70,995)	56,726			10a
11	Activities	216,048	6,830	7,664	230,542		230,542	(105,006)	125,536			11
12	Social Services	102,139	6,883	28,629	137,651		137,651	(56,077)	81,574			12
13	CNA Training											13
14	Program Transportation	31,262	9,450	24,366	65,078		65,078	(34,957)	30,121			14
15	Other (specify):* See Supplemental											15
16	TOTAL Health Care and Programs	3,928,871	208,958	191,417	4,329,246		4,329,246	(350,788)	3,978,458			16
	C. General Administration											
17	Administrative	240,235		1,201,632	1,441,867		1,441,867	(806,035)	635,832			17
18	Directors Fees											18
19	Professional Services			53,432	53,432		53,432	(27,739)	25,693			19
20	Dues, Fees, Subscriptions & Promotions			57,045	57,045		57,045	(25,847)	31,198			20
21	Clerical & General Office Expenses	459,614	47,864	245,748	753,226		753,226	(447,643)	305,583			21
22	Employee Benefits & Payroll Taxes			1,922,869	1,922,869		1,922,869	(14,970)	1,907,899			22
23	Inservice Training & Education			5,764	5,764		5,764	(3,208)	2,556			23
24	Travel and Seminar			2,525	2,525		2,525	(1,405)	1,120			24
25	Other Admin. Staff Transportation			3,738	3,738		3,738	(1,997)	1,741			25
26	Insurance-Prop.Liab.Malpractice			203,828	203,828		203,828	(92,354)	111,474			26
27	Other (specify):* See Supplemental											27
28	TOTAL General Administration	699,849	47,864	3,696,581	4,444,294		4,444,294	(1,421,198)	3,023,096			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,553,209	1,363,940	5,567,368	13,484,517		13,484,517	(4,340,542)	9,143,975			29

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

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			1,301,718	1,301,718		1,301,718	(885,966)	415,752			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,018,299	1,018,299		1,018,299	(693,132)	325,167			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			22,370	22,370		22,370	(12,452)	9,918			35
36	Other (specify):* See Supplemental											36
37	TOTAL Ownership			2,342,387	2,342,387		2,342,387	(1,591,550)	750,837			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		169,163	656,402	825,565		825,565		825,565			39
40	Barber and Beauty Shops		554	79,150	79,704		79,704	(79,704)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			215,048	215,048		215,048		215,048			42
43	Other (specify):* See Supplemental	1,240,679	132,117	252,352	1,625,148		1,625,148	(1,625,148)				43
44	TOTAL Special Cost Centers	1,240,679	301,834	1,202,952	2,745,465		2,745,465	(1,704,852)	1,040,613			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	7,793,888	1,665,774	9,112,707	18,572,369		18,572,369	(7,636,944)	10,935,425			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

Addolorata Villa
Medicaid Cost Report
07/01/15 - 06/30/16

Page 4 Supplemental Schedule

Description	Salaries		Supplies		Other		Total	
Line 36 - Other Capital Costs								
								-
								-
								-
								-
								-
								-
Sub-Total		-		-		-		-
Line 43 - Other Special Cost Centers								
Assisted Living		823,681		46,152		37,078		906,911
Fundraising		69,610		22,553		58,493		150,656
Independent Living		45,903		31,449		17,934		95,286
Marketing		229,969		30,497		135,760		396,226
Volunteers		-		1,466		3,087		4,553
Mission Integration		71,516		-		-		71,516
Sub-Total		1,240,679		132,117		252,352		1,625,148

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	(16,887)	02		4
5	Telephone, TV & Radio in Resident Rooms	(31,369)	21		5
6	Rented Facility Space	(2,430)	06		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(14,970)	22		8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(202)	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	(877)	21		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	(153,496)	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 Supplemental Schedule	(7,137,451)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (7,357,682)		\$	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)	(279,262)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (279,262)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (7,636,944)		37

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Beauty Shop Revenue (To Extent of Expense)	\$ (79,704)	40	1
2	Activity Revenue	(10,787)	11	2
3	Rebates & Refunds	(7,552)	21	3
4	Miscellaneous Revenue	(225)	21	4
5	Cable	(106,215)	05	5
6	Senior Fit	(70,995)	10a	6
7	Collections / Legal	(6,453)	19	7
8	Bank Fees	(975)	21	8
9	Assisted Living	(906,911)	43	9
10	Fund Raising	(150,656)	43	10
11	Independent Living	(95,286)	43	11
12	Marketing	(396,226)	43	12
13	Volunteers	(4,553)	43	13
14	Mission Integration	(71,516)	43	14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23	AL / IL Allocations - See Pg 5 SUPP			23
24				24
25	Dietary - Indirect Allocation	(710,591)	01	25
26	Food Purchases - Indirect Allocation	(308,326)	02	26
27	Housekeeping - Indirect Allocation	(274,813)	03	27
28	Laundry - Indirect Allocation	(58,304)	04	28
29	Heat and Other Utilities - Indirect Allocation	(301,764)	05	29
30	Maintenance - Indirect Allocation	(789,226)	06	30
31	Medical Director - Indirect Allocation	(3,663)	09	31
32	Nursing and Medical Records - Indirect Allocation	(80,090)	10	32
33	Rehab Aides - Indirect Allocation	0	10a	33
34	Activities - Indirect Allocation	(94,219)	11	34
35	Social Services - Indirect Allocation	(56,077)	12	35
36	Program Transportation - Indirect Allocation	(34,957)	14	36
37	Administrative - Indirect Allocation	(526,773)	17	37
38	Professional Fees - Indirect Allocation	(21,286)	19	38
39	Dues and Subscriptions - Indirect Allocation	(25,847)	20	39
40	Clerical & General Office - Indirect Allocation	(253,149)	21	40
41	Inservice Training and Education - Indirect Alloc	(3,208)	23	41
42	Travel and Seminar - Indirect Allocation	(1,405)	24	42
43	Other Admin Staff Transportation - Indirect Alloc	(1,997)	25	43
44	Insurance - Indirect Allocation	(92,354)	26	44
45	Depreciation - Indirect Allocation	(885,966)	30	45
46	Amortization - Indirect Allocation	0	31	46
47	Interest - Indirect Allocation	(692,930)	32	47
48	Rent - Equipment - Indirect Alloc	(12,452)	35	48
49	Total	(7,137,451)		49

Addolorata Villa
Medicaid Cost Report
07/01/15 - 06/30/16

Page 5 - Non-Care Supplemental Allocation Schedule

Page 5 - Non-Care Supplemental Allocation Schedule				Direct Nursing Home			Statistics			Expenses	
Description	Cost Center	Salary	Total Allow. Exp.	Salary	Other	Expenses For Alloc.	Alloc. Method	Nursing Home	Total	Nursing Home	Other
Dietary	01	926,081	1,574,243		12,323	1,561,920	Meals Served	105,840	194,183	863,652	710,591
Food	02	-	711,838		34,119	677,719	Meals Served	105,840	194,183	403,512	308,326
Housekeeping	03	468,041	545,483			545,483	SQFT (1)	932,582	1,879,442	270,670	274,813
Laundry	04	71,771	135,988			135,988	Pat. Days (1)	35,280	61,759	77,684	58,304
Heat and Other Utilities	05	-	443,371			443,371	SQFT	66,613	208,565	141,607	301,764
Maintenance	06	458,596	1,174,522		14,940	1,159,582	SQFT	66,613	208,565	385,296	789,226
Other	07	-	-			-	Pat. Days	35,280	79,571	-	-
Medical Director	09	-	25,200			25,200	Dir. Staffing	3,054,618	3,574,227	21,537	3,663
Nursing and Medical Records	10	3,524,468	3,743,054	2,999,664	192,475	550,915	Dir. Staffing	3,054,618	3,574,227	3,662,964	80,090
Therapy	10a	54,954	56,726	54,954	1,772	-	Dir. Staffing	3,054,618	3,574,227	56,726	-
Activities	11	216,048	219,755			219,755	Pat. Days (2)	35,280	61,759	125,536	94,219
Social Services	12	102,139	137,651			137,651	Pat. Days (3)	35,280	59,533	81,574	56,077
CNA Training	13	-	-			-	Dir. Staffing				-
Transportation	14	31,262	65,078		2,276	62,802	Pat. Days	35,280	79,571	30,121	34,957
Other	15	-	-			-	Pat. Days	35,280	79,571	-	-
Administrative	17	240,235	1,162,605			1,162,605	Net. Pat. Rev.	10,423,408	19,058,963	635,832	526,773
Directors Fees	18	-	-			-	N/A				-
Professional Fees	19	-	46,979			46,979	Net. Pat. Rev.	10,423,408	19,058,963	25,693	21,286
Dues and Subscriptions	20	-	57,045			57,045	Net. Pat. Rev.	10,423,408	19,058,963	31,198	25,847
Office and Clerical	21	459,614	558,732		23	558,709	Net. Pat. Rev.	10,423,408	19,058,963	305,583	253,149
Employee Benefits	22	-	1,907,899			1,907,899	Alloc. Salary	5,008,160	7,793,888	1,225,969	681,930
Inservice Training and Expense	23	-	5,764			5,764	Pat. Days	35,280	79,571	2,556	3,208
Travel and Seminar	24	-	2,525			2,525	Pat. Days	35,280	79,571	1,120	1,405
Other Staff Transportation	25	-	3,738		150	3,588	Pat. Days	35,280	79,571	1,741	1,997
Insurance	26	-	203,828			203,828	Net. Pat. Rev.	10,423,408	19,058,963	111,474	92,354
Other	27	-	-			-	N/A				-
Depreciation	30	-	1,301,718			1,301,718	SQFT	66,613	208,565	415,752	885,966
Amortization	31	-	-			-	Net. Pat. Rev.	10,423,408	19,058,963	-	-
Interest	32	-	1,018,097			1,018,097	SQFT	66,613	208,565	325,167	692,930
Real Estate Taxes	33	-	-			-	SQFT	66,613	208,565	-	-
Rent - Facilities and Grounds	34	-	-			-	SQFT	66,613	208,565	-	-
Rent - Equipment and Vehicles	35	-	22,370			22,370	Pat. Days	35,280	79,571	9,918	12,452
Other	36	-	-			-	N/A				-
Medically Necessary Transportation	38	-	-			-	N/A				-
Ancillary Service Centers	39	-	825,565			825,565	Direct	1	1	825,565	-
Barber and Beauty Shop	40	-	-			-	Direct	1	1	-	-
Coffee and Gift Shops	41	-	-			-	Direct	1	1	-	-
Provider Participation Fee	42	-	215,048			215,048	Direct	1	1	215,048	-
Other	43	1,240,679	-			-	Direct		1	-	-
		7,793,888	16,164,822	3,054,618	258,078	12,852,126				10,253,495	5,911,327

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Addolorata Villa# 0045443

Report Period Beginning:

07/01/15

Ending:

06/30/16

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	(710,591)	0	0	0	0	0	0	0	0	0	0	(710,591)	1
2	Food Purchase	(325,213)	0	0	0	0	0	0	0	0	0	0	(325,213)	2
3	Housekeeping	(274,813)	0	0	0	0	0	0	0	0	0	0	(274,813)	3
4	Laundry	(58,304)	0	0	0	0	0	0	0	0	0	0	(58,304)	4
5	Heat and Other Utilities	(407,979)	0	0	0	0	0	0	0	0	0	0	(407,979)	5
6	Maintenance	(791,656)	0	0	0	0	0	0	0	0	0	0	(791,656)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(2,568,556)	0	0	0	0	0	0	0	0	0	0	(2,568,556)	8
	B. Health Care and Programs													
9	Medical Director	(3,663)	0	0	0	0	0	0	0	0	0	0	(3,663)	9
10	Nursing and Medical Records	(80,090)	0	0	0	0	0	0	0	0	0	0	(80,090)	10
10a	Therapy	(70,995)	0	0	0	0	0	0	0	0	0	0	(70,995)	10a
11	Activities	(105,006)	0	0	0	0	0	0	0	0	0	0	(105,006)	11
12	Social Services	(56,077)	0	0	0	0	0	0	0	0	0	0	(56,077)	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(34,957)	0	0	0	0	0	0	0	0	0	0	(34,957)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(350,788)	0	0	0	0	0	0	0	0	0	0	(350,788)	16
	C. General Administration													
17	Administrative	(526,773)	(279,262)	0	0	0	0	0	0	0	0	0	(806,035)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(27,739)	0	0	0	0	0	0	0	0	0	0	(27,739)	19
20	Fees, Subscriptions & Promotions	(25,847)	0	0	0	0	0	0	0	0	0	0	(25,847)	20
21	Clerical & General Office Expenses	(447,643)	0	0	0	0	0	0	0	0	0	0	(447,643)	21
22	Employee Benefits & Payroll Taxes	(14,970)	0	0	0	0	0	0	0	0	0	0	(14,970)	22
23	Inservice Training & Education	(3,208)	0	0	0	0	0	0	0	0	0	0	(3,208)	23
24	Travel and Seminar	(1,405)	0	0	0	0	0	0	0	0	0	0	(1,405)	24
25	Other Admin. Staff Transportation	(1,997)	0	0	0	0	0	0	0	0	0	0	(1,997)	25
26	Insurance-Prop.Liab.Malpractice	(92,354)	0	0	0	0	0	0	0	0	0	0	(92,354)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(1,141,936)	(279,262)	0	0	0	0	0	0	0	0	0	(1,421,198)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(4,061,280)	(279,262)	0	0	0	0	0	0	0	0	0	(4,340,542)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Addolorata Villa # 0045443 Report Period Beginning: 07/01/15 Ending: 06/30/16

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	(885,966)	0	0	0	0	0	0	0	0	0	0	(885,966) 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	(693,132)	0	0	0	0	0	0	0	0	0	0	(693,132) 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	(12,452)	0	0	0	0	0	0	0	0	0	0	(12,452) 35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 36
37	TOTAL Ownership	(1,591,550)	0	0	0	0	0	0	0	0	0	0	(1,591,550) 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	(79,704)	0	0	0	0	0	0	0	0	0	0	(79,704) 40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0 41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0 42
43	Other (specify):*	(1,625,148)	0	0	0	0	0	0	0	0	0	0	(1,625,148) 43
44	TOTAL Special Cost Centers	(1,704,852)	0	0	0	0	0	0	0	0	0	0	(1,704,852) 44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(7,357,682)	(279,262)	0	0	0	0	0	0	0	0	0	(7,636,944) 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	\$ 1,201,632	Franciscan Sisters of Chicago Service Corporation	100.00%	\$ 922,370	\$ (279,262)	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			\$ 1,201,632			\$ 922,370	\$ * (279,262)	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Addolorata Villa # 0045443 Report Period Beginning: 07/01/15 Ending: 06/30/16

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	President & CEO	0.00%	See Supplemental	4.99	12.47%	Alloc. Salary	\$ 24,942	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	\$ 24,942		13

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Addolorata Villa
Medicaid Cost Report
07/01/15 - 06/30/16

Page 7 Supplemental Schedule

Description	Alloc. Hours	Total Hours	Alloc. Percentage	Total Compensation			Alloc. Compensation	
				Salary	Mgmt. Fees		Salary	Mgmt. Fees
Owners / Director Compensation - Judy Amiano (President & CEO)								
Addolorata Villa	4.99	40	12.47%	200,000	-		24,942	-
Franciscan Village	5.86	40	14.65%	200,000	-		29,304	-
St. Joseph Village	2.39	40	5.97%	200,000	-		11,945	-
Village at Victory Lakes	5.99	40	14.98%	200,000	-		29,950	-
Other	20.77	40	51.93%	200,000	-		103,858	-
							-	-
							-	-
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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	\$ 18,090,000	\$ 18,054,000	05/01/37	5.5000%	\$ 568,660	1	
2	Amalgamated Bank		X	Facility Acquisition	Varies	03/17/13	11,484,294	10,892,524	05/01/47	4.8600%	343,090	2	
3	Huntington Bank		X	Facility Acquisition	Varies	03/17/13	1,474,166	1,375,778	05/01/43	Variable	43,334	3	
4	Huntington Bank		X	Facility Acquisition	Varies	03/17/13	2,162,593	2,006,982	05/01/43	Variable	63,215	4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$ 33,211,053	\$ 32,329,284			\$ 1,018,299	9	
	B. Non-Facility Related*												
10	Interest Income										(202)	10	
11												11	
12	Allocation - IL / AL										(692,930)	12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ (693,132)	14	
15	TOTALS (line 9+line14)						\$ 33,211,053	\$ 32,329,284			\$ 325,167	15	

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

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

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

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 2015 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 2016 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:		2011		8	
		2012		9	
		2013		10	
		2014		11	
		2015		12	
N/A - Addolorata Villa is exempt from real estate taxes.				13	FOR BHF USE ONLY
				13	FROM R. E. TAX STATEMENT FOR 2015 \$
				14	PLUS APPEAL COST FROM LINE 5 \$
				15	LESS REFUND FROM LINE 6 \$
				16	AMOUNT TO USE FOR RATE CALCULATION \$

NOTES:

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

SEE ACCOUNTANTS' PREPARATION REPORT

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME	Addolorata Villa	COUNTY	Cook
---------------	------------------	--------	------

FACILITY IDPH LICENSE NUMBER 0045443

CONTACT PERSON REGARDING THIS REPORT Edward N. Slack, CPA

TELEPHONE (847) 628 - 8796 FAX #: (248) 327 - 8417

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2015 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 2015.

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

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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: 66,613

B. General Construction Type: Exterior Brick Frame Number of Stories 2

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).

Indepenent Living - 80,036 Square Feet (100 Units)

Assisted Living - 59,584 Square Feet (65 Units)

Outpatient Therapy - 2,332 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:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility		1996	\$ 644,127	1
2	Alloc. - Convent			28,094	2
3	TOTALS			\$ 672,221	3

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Addolorata Villa

0045443

Report Period Beginning:

07/01/15

Ending:

06/30/16

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	88				\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1996	5,181,017						9
10	Various			1997	571,578						10
11	Various			1998	179,798						11
12	Various			1999	301,948						12
13	Various			2000	2,510,370						13
14	Various			2001	81,111						14
15	Various			2002	118,623						15
16	Various			2003	50,998						16
17	Various			2004	534						17
18	Various			2005	22,055						18
19	Various			2006	59,090						19
20	Various			2007	194,257						20
21	Various			2008	19,504						21
22	Various			2009	22,823						22
23	Various			2010	69,766						23
24	Various			2011	158,756						24
25	Various			2012	125,020						25
26	Main Support Posts on Pavillion (TC = \$8,501)			2013	2,715						26
27	Signs (TC = \$11,816)			2013	3,774						27
28	Doors - Basement and Cabernet (TC = \$6,500)			2013	2,076						28
29	Sprinkler Piping, Metal Framing, Piping (TC = \$124,879)			2013	39,885						29
30	Flooring and Final Base (TC = \$60,378)			2013	19,284						30
31	PCB Assembly Board (TC = \$6,139)			2013	1,961						31
32	Change Latching Flushbolts (TC = \$2,930)			2013	936						32
33	Temp Sensor - Boiler Room (TC = \$4,891)			2013	852						33
34	Boiler Repairs (TC = \$4,891)			2013	1,562						34
35	Shaft and Bearing Fans - Cooling Tower (TC = \$4,706)			2013	1,503						35
36	Glycol Leak Pumps and Heating Pumppts (TC = \$4,959)			2013	1,584						36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Addolorata Villa

0045443

Report Period Beginning:

07/01/15

Ending:

06/30/16

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 <u>Roof Replacement - Admin., Chapel, Sheltered (TC = \$403,187)</u>	2013	\$ 128,773	\$		\$	\$	\$	37
38 <u>Painting - Gazebo (TC = \$5,500)</u>	2013	1,757						38
39 <u>Masonry - Admin, Chapel, and Sheltered (TC = \$95,060)</u>	2014	30,361						39
40 <u>Wall Panels - Kitchen (TC = \$10,867)</u>	2013	3,471						40
41 <u>Hot Water System and Heat Booster (TC = \$84,560)</u>	2013	27,007						41
42 <u>Plumbing and Piping - Kitchen (TC = \$17,462)</u>	2013	5,577						42
43 <u>Electrical for Chef Power Line - Kitchen (TC = \$3,468)</u>	2013	1,108						43
44 <u>Counters - Kitchen (TC = \$38,343)</u>	2013	12,246						44
45 <u>Rooftop and PTAC AC Units (TC = \$38,536)</u>	2014	12,308						45
46 <u>Audio and Sound System - Chapel (TC = \$22,234)</u>	2014	7,101						46
47 <u>Mixing Valves - Plumbing (TC = \$3,485)</u>	2014	1,113						47
48 <u>Design and Site Fees - LIMP Improvements (TC = \$5,791)</u>	2014	2,302						48
49 <u>Automated Access Door Devices - Entrance (TC = \$26,610)</u>	2014	14,046						49
50 <u>Elevator Upgrades - Electrical, Pumps, Etc. (TC = \$272,230)</u>	2014	86,947						50
51 <u>Annunciator Panel - Nurses Station (TC = \$2,689)</u>	2014	1,556						51
52 <u>Heat Pump - Admin, Chapel, Sheltered (TC = \$32,785)</u>	2014	10,471						52
53 <u>Smoke Detectors - Admin, Chapel, Sheltered (TC = \$23,619)</u>	2013	7,544						53
54 <u>Laundry Ejector Pump - Laundry Room (TC = \$10,069)</u>	2013	10,069						54
55 <u>Fire Alarm - Admin, Chapel, Sheltered (TC = \$9,998)</u>	2014	3,193						55
56 <u>Sprinkler System (TC = \$142,649)</u>	2014	45,560						56
57 <u>Diesel Tanks - Repiped to Generator (TC = \$19,734)</u>	2015	6,303						57
58 <u>Automated Access Door Devices - Entrance (TC = \$12,300)</u>	2015	7,500						58
59 <u>Electrical Panels - Kitchen and NH (TC = \$65,730)</u>	2015	20,993						59
60 <u>Fire Alarm System / Wiring - Kitchen and NH (TC = \$32,112)</u>	2014	10,256						60
61 <u>Fire Damper - Kitchen and NH (TC = \$6,775)</u>	2015	2,164						61
62 <u>Parking Lot - Demo and Rehab (TC = \$508,233)</u>	2014	162,323						62
63 <u>Block Wall Replacement - Demo and Rehab (TC = \$7,616)</u>	2014	2,432						63
64 <u>Ejector Pump - Sewage System (TC = \$19,077)</u>	2015	6,093						64
65 <u>Heat Pumps - (TC = \$6,775)</u>	2015	2,164						65
66								66
67								67
68								68
69								69
70 TOTAL (lines 4 thru 69)		\$ 10,376,118	\$		\$	\$	\$	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 10,376,118	\$		\$	\$	\$	1
2									2
3	Current Year Additions FY 2015 - 2016								3
4									4
5	Fire Doors (TC = \$6,450)	2016	6,450						5
6	Carpeting - Rehab Room (TC = \$11,847)	2016	11,847						6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,394,415	\$		\$	\$	\$	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

Addolorata Villa
Medicaid Cost Report
07/01/15 - 06/30/16

Page 12D - CY Leasehold Improvement Additions

[illegible]

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	
1 Totals from Page 12B, Carried Forward		\$ 10,394,415	\$		\$	\$	\$	1
2								2
3 Disposals								3
4								4
5 See PY FA Disposition Schedule - Allocations and Locations								5
6								6
7 Various (TC = \$49,914)	1996	(15,942)						7
8 Various (TC = \$10,700)	1998	(3,417)						8
9 Various (TC = \$22,865)	2008	(7,303)						9
10 Various (TC = \$347)	2008	(111)						10
11 Various (TC = \$7,965)	2009	(2,544)						11
12								12
13								13
14								14
15 See CY FA Disposition Schedule - Allocations and Locations								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33 Financial Statement Depreciation			415,752		415,752		6,139,691	33
34 TOTAL (lines 1 thru 33)		\$ 10,365,098	\$ 415,752		\$ 415,752	\$	\$ 6,139,691	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

Addolorata Villa
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Page 12E - CY Leasehold Improvement Dispositions

Description	Acquisiton Date	Cost	Class	Method	Capitalized		Expensed	
					Nursing Home	Other	Nursing Home	Other
Non-Care	Various	96,552	LIMP	Direct - OTH	-	96,552	-	-
		96,552			-	96,552	-	-

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	\$1,558,537	\$	\$	\$		\$	71
72	Current Year Purchases	31,741						72
73	Fully Depreciated Assets							73
74	Disposals							74
75	TOTALS	\$1,590,278	\$	\$	\$		\$	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		2001	\$11,548	\$	\$	\$		\$	76
77	Facility		2008	31,493						77
78	Facility		2008	611						78
79										79
80	TOTALS			\$43,652	\$	\$	\$		\$	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)	\$12,671,249	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$415,752	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$415,752	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$6,139,691	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	\$22,382,070	\$	\$	86
87	Non-Care Assets - CY LIMP Add.	885,775			87
88	Non-Care Assets - CY EQIP Add.	74,955			88
89	Non-Care Assets - CY Disposals	(123,345)			89
90	Financial Statement Depreciation		885,966	13,083,659	90
91	TOTALS	\$23,219,455	\$885,966	\$13,083,659	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.

SEE ACCOUNTANTS' PREPARATION REPORT

Addolorata Villa
Medicaid Cost Report
07/01/15 - 06/30/16

Page 13 - CY Equipment, Furniture and Vehicle Additions

[illegible]

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07/01/15 - 06/30/16

Page 13 - CY Equipment, Furniture and Vehicle Dispositions

[illegible]

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? YES NO
- If NO, see instructions.

		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: \$ 9,918 Description: See Supplemental Schedule
(Attach a schedule detailing the breakdown of movable equipment)

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.	<u> </u> /2017	\$ <u> </u>
13.	<u> </u> /2018	\$ <u> </u>
14.	<u> </u> /2019	\$ <u> </u>

C. Vehicle Rental (See instructions.)

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Description		Amount		Total
Building Rental				
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
Total		-		-
Equipment Rental				
Copiers		19,454		19,454
Postage Machine		1,524		1,524
Other		1,392		1,392
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
Alloc. - IL / AL				(12,452)
Total		9,918		9,918

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

		1	2		3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		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	39 - 03	hrs	\$		\$	250,610	\$		\$	250,610	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				73,675				73,675	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39 - 03	hrs				287,657				287,657	4
5	Physician Care		visits									5
6	Dental Care		visits									6
7	Work Related Program		hrs									7
8	Habilitation		hrs									8
9	Pharmacy	39 - 02	# of prescrpts					158,132			158,132	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Other (specify): See Supplemental	39 - 02						11,031			11,031	12
13	Other (specify): See Supplemental	39 - 03					44,460				44,460	13
14	TOTAL			\$		\$	656,402	\$	169,163	\$	825,565	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Addolorata Villa
Medicaid Cost Report
07/01/15 - 06/30/16

Page 16 Supplemental Schedule

[illegible]

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	\$ 720	\$	1
2	Cash-Patient Deposits	6,711		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	574,133		3
4	Supply Inventory (priced at <u>Cost - FIFO</u>)	209,025		4
5	Short-Term Investments			5
6	Prepaid Insurance	212,696		6
7	Other Prepaid Expenses	130,397		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Supplemental Schedule</u>	39,110		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,172,792	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	2,962,633		13
14	Buildings, at Historical Cost	7,468,957		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	25,279,951		16
17	Accumulated Depreciation (book methods)	(19,223,350)		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>	25,830		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 16,514,021	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 17,686,813	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 585,117	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	6,711		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	667,088		30
31	Accrued Taxes Payable (excluding real estate taxes)	7,772		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	9,750		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Supplemental Schedule</u>	1,130,225		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,406,663	\$	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)	\$ 2,406,663	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 15,280,150	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 17,686,813	\$	48

SEE ACCOUNTANTS' PREPARATION REPORT

*(See instructions.)

Addolorata Villa
Medicaid Cost Report
07/01/15 - 06/30/16

Page 17 Supplemental Schedule

Description		Operating		Building		Total
Line 9 - Other Current Assets						
Other Current Receivables		39,110				39,110
Sub-Total		39,110		-		39,110
Line 23 - Long Term Assets						
Construction in Progress		25,830				25,830
Sub-Total		25,830		-		25,830
Line 36 - Other Current Liability						
Refundable Deposits		800,925				800,925
Unrefundable Deposits (Net of Amort.)		151,678				
Life Annuity Contracts		50,000				
Asset Retirement Obligations		122,394				
Unclaimed Funds		5,228				
Sub-Total		1,130,225		-		1,130,225
Line 43 - Long term Liabilities						
						-
Sub-Total		-		-		-

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 15,072,805	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 15,072,805	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,035,507	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)	\$ 1,035,507	17
	B. Transfers (Itemize):		
18	FC Holding - Intercompany Transfer	(873,012)	18
19	Net Assets Released - Temporarily Restricted	44,850	19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (828,162)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 15,280,150	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Addolorata Villa

0045443

Report Period Beginning:

07/01/15

Ending:

06/30/16

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

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

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 19,058,963	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 19,058,963	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	204,050	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 204,050	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	88,541	13
14	Non-Patient Meals	16,887	14
15	Telephone, Television and Radio	54,314	15
16	Rental of Facility Space	2,430	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	5,691	21
22	Laundry	32,295	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 200,158	23
	D. Non-Operating Revenue		
24	Contributions	125,939	24
25	Interest and Other Investment Income***	202	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 126,141	26
	E. Other Revenue (specify).****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	18,564	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 18,564	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 19,607,876	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	4,710,977	31
32	Health Care	4,329,246	32
33	General Administration	4,444,294	33
	B. Capital Expense		
34	Ownership	2,342,387	34
	C. Ancillary Expense		
35	Special Cost Centers	2,530,417	35
36	Provider Participation Fee	215,048	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 18,572,369	40
41	Income before Income Taxes (line 30 minus line 40)**	1,035,507	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,035,507	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 810,414	44
45	Private Pay - Net Inpatient Revenue	7,103,433	45
46	Medicare - Net Inpatient Revenue	2,321,880	46
47	Other-(specify) <u>Insurance - Net Patient Revenue</u>	187,681	47
48	Other-(specify) <u>Private Pay - Assisted and Independent Living</u>	8,635,555	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 19,058,963	49

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

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Addolorata Villa
Medicaid Cost Report
07/01/15 - 06/30/16

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[illegible]

Facility Name & ID Number Addolorata Villa# 0045443

Report Period Beginning:

07/01/15

Ending:

06/30/16

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	1,635	1,857	\$ 86,290	\$ 46.47	1
2	Assistant Director of Nursing	2,903	3,097	123,284	39.81	2
3	Registered Nurses	37,220	41,556	1,492,440	35.91	3
4	Licensed Practical Nurses	10,913	12,403	343,459	27.69	4
5	CNAs & Orderlies	78,733	88,063	1,365,224	15.50	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,463	2,819	54,954	19.49	8
9	Activity Director	1,510	2,094	60,574	28.93	9
10	Activity Assistants	9,930	11,208	155,474	13.87	10
11	Social Service Workers	3,435	4,119	102,139	24.80	11
12	Dietician	1,749	1,954	27,986	14.32	12
13	Food Service Supervisor	2,335	2,489	47,388	19.04	13
14	Head Cook	13,283	15,058	238,110	15.81	14
15	Cook Helpers/Assistants	49,499	53,829	612,597	11.38	15
16	Dishwashers					16
17	Maintenance Workers	17,106	19,225	458,596	23.85	17
18	Housekeepers	32,485	36,943	468,041	12.67	18
19	Laundry	5,450	6,193	71,771	11.59	19
20	Administrator	1,272	1,449	88,157	60.84	20
21	Assistant Administrator					21
22	Other Administrative	1,824	2,093	152,078	72.66	22
23	Office Manager					23
24	Clerical	21,397	23,559	459,614	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	1,859	2,053	31,744	15.46	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	63,644	70,668	1,353,968	19.16	33
34	TOTAL (lines 1 - 33)	360,645	402,729	\$ 7,793,888 *	\$ 19.35	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		25,200	09 - 03	36
37	Medical Records Consultant		792	10 - 03	37
38	Nurse Consultant		31,528	10 - 03	38
39	Pharmacist Consultant		2,243	10 - 03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant		648	11 - 03	44
45	Social Service Consultant		917	12 - 03	45
46	Other(specify)				46
47	<u>See Supplemental Schedule</u>		578,620		47
48					48
49	TOTAL (lines 35 - 48)		\$ 639,948		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

SEE ACCOUNTANTS' PREPARATION REPORT

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

** See instructions.

Addolorata Villa
Medicaid Cost Report
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Page 20 Supplemental Schedule

Description	CC Reference	Hours Worked	Hours Paid	Salary	Average Rate	Hours Paid	Contracted Cost
Nursing Home Employees							
Nursing Admin. Support	10	4,047	4,404	82,027	18.63		
Transportation Attendant	14	1,587	1,894	31,262	16.51		
Assisted Living	43	46,786	51,768	823,681	15.91		
Fund Raising	43	1,841	2,090	69,610	33.31		
Independent Living	43	1,954	2,086	45,903	22.01		
Marketing	43	5,639	6,471	229,969	35.54		
Director of Mission Integration	43	1,790	1,955	71,516	36.58		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
Total		63,644	70,668	1,353,968	19.16		

Contracted Services							
Dietary Management	01						105,364
Dietary Contracted Services	01						374,549
Senior Fit	10A						70,995
Priest	12						13,384
Organist	12						14,328
Total						-	578,620

XIX. SUPPORT SCHEDULES

[illegible]

*** Attach copy of IMRF notifications
SEE ACCOUNTANTS' PREPARATION REPORT**

****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?

Yes

If YES, give association name and amount.

LeadingAge \$16,298

(3) Did the nursing home make political contributions or payments to a political action organization?

No

If YES, have these costs been properly adjusted out of the cost report?

N/A

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?

No

If YES, what is the capacity?

N/A

(5) Have you properly capitalized all major repairs and equipment purchases?

Yes

What was the average life used for new equipment added during this period?

5 - 10 Yrs

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$

60,740

 Line

10 - 02

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

Yes

If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement?

No

If YES, give effective date of lease.

N/A

(9) Are you presently operating under a sublease agreement?

YES

X

NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO

X

 If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$

215,048

This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?

No

If YES, attach an explanation of the allocation.

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

Yes

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

Yes - See Pg. 11

 For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$

0

 Has any meal income been offset against related costs?

Yes

 Indicate the amount. \$

16,887

(16) Travel and Transportation

a. Are there costs included for out-of-state travel?

No

If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents?

No

 If YES, please indicate the amount of income earned from such a program during this reporting period. \$

N/A

c. What percent of all travel expense relates to transportation of nurses and patients?

Ln 14

d. Have vehicle usage logs been maintained?

Yes

e. Are all vehicles stored at the nursing home during the night and all other times when not in use?

Yes

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

Yes

g. Does the facility transport residents to and from day training?

No

Indicate the amount of income earned from providing such transportation during this reporting period. \$

N/A

(17) Has an audit been performed by an independent certified public accounting firm?

Yes

Firm Name:

Plante & Moran, PLLC - Consolidated Statement

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

Yes - Alloc. Basis

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details.

Yes

Attach invoices and a summary of services for all architect and appraisal fees

SEE ACCOUNTANTS' PREPARATION REPORT

HFS 3745 (N-4-99)

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