

Facility Name & ID Number ST PAULS HOUSE AND H C CTR

0005165 Report Period Beginning: 07/01/01 Ending: 06/30/02

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 _____

	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	141	Skilled (SNF)	141	51,465	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	64	Sheltered Care (SC)	64	23,360	5
6		ICF/DD 16 or Less			6
7	205	TOTALS	205	74,825	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				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	20,008	19,737	5,877	45,622	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC		17,862		17,862	12
13	DD 16 OR LESS					13
14	TOTALS	20,008	37,599	5,877	63,484	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.84%

D. How many bed-hold days during this year were paid by Public Aid? None (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)

Meals on Wheels

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 11/24/74

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 21 and days of care provided 5,516

Medicare Intermediary AdminaStar Illinois

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 06/02 Fiscal Year: 06/02

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

Facility Name & ID Number ST PAULS HOUSE AND H C CTR # 0005165 Report Period Beginning: 07/01/01 Ending: 06/30/02

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 OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	330,922	48,514	183,632	563,068		563,068		563,068		1
2	Food Purchase		324,250		324,250	(11,373)	312,877	(9,059)	303,818		2
3	Housekeeping	150,503	(37)	171,179	321,645		321,645		321,645		3
4	Laundry	58,794	16,549		75,343		75,343		75,343		4
5	Heat and Other Utilities			261,388	261,388		261,388		261,388		5
6	Maintenance	184,365	92,745	148,186	425,296		425,296		425,296		6
7	Other (specify):*										7
8	TOTAL General Services	724,584	482,021	764,385	1,970,990	(11,373)	1,959,617	(9,059)	1,950,558		8
	B. Health Care and Programs										
9	Medical Director			10,000	10,000		10,000		10,000		9
10	Nursing and Medical Records	2,112,569	197,464	336,164	2,646,197		2,646,197	(2,119)	2,644,078		10
10a	Therapy			76,201	76,201		76,201		76,201		10a
11	Activities	119,300	13,719	400	133,419		133,419	(12,285)	121,134		11
12	Social Services	258,336	1,673	4,865	264,874		264,874		264,874		12
13	Nurse Aide Training										13
14	Program Transportation			1,263	1,263		1,263		1,263		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,490,205	212,856	428,893	3,131,954		3,131,954	(14,404)	3,117,550		16
	C. General Administration										
17	Administrative	122,773			122,773		122,773		122,773		17
18	Directors Fees										18
19	Professional Services			332,169	332,169		332,169	(1,845)	330,324		19
20	Dues, Fees, Subscriptions & Promotions			93,019	93,019		93,019	(40,033)	52,986		20
21	Clerical & General Office Expenses	376,883	59,455	235,443	671,781		671,781	(163,471)	508,310		21
22	Employee Benefits & Payroll Taxes			733,924	733,924	11,373	745,297		745,297		22
23	Inservice Training & Education										23
24	Travel and Seminar			7,957	7,957		7,957	(1,370)	6,587		24
25	Other Admin. Staff Transportation			1,019	1,019		1,019		1,019		25
26	Insurance-Prop.Liab.Malpractice			123,827	123,827		123,827		123,827		26
27	Other (specify):*										27
28	TOTAL General Administration	499,656	59,455	1,527,358	2,086,469	11,373	2,097,842	(206,719)	1,891,123		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,714,445	754,332	2,720,636	7,189,413		7,189,413	(230,182)	6,959,231		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number

ST PAULS HOUSE AND H C CTR

#0005165

Report Period Beginning:

07/01/01

Ending:

06/30/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			557,689	557,689		557,689	85,737	643,426			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			251,503	251,503		251,503	(72,113)	179,390			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			40,045	40,045		40,045		40,045			35
36	Other (specify):*			13,008	13,008		13,008		13,008			36
37	TOTAL Ownership			862,245	862,245		862,245	13,624	875,869			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		558,941	589,759	1,148,700		1,148,700		1,148,700			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			77,622	77,622		77,622	(425)	77,197			42
43	Other (specify):*	110,072	12,764	78,205	201,041		201,041	(201,041)				43
44	TOTAL Special Cost Centers	110,072	571,705	745,586	1,427,363		1,427,363	(201,466)	1,225,897			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,824,517	1,326,037	4,328,467	9,479,021		9,479,021	(418,024)	9,060,997			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(9,059)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	85,737	30		9
10	Interest and Other Investment Income	(13,377)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		02		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	(385)	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	(120,203)	21		24
25	Fund Raising, Advertising and Promotional	(40,033)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(353,815)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (451,135)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	33,111		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 33,111		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (418,024)		37

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

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

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

OHF USE ONLY					
48		49		50	
				51	
				52	

SEE ACCOUNTANTS' COMPILATION REPORT

DW 0005165
 Report Period Beginning: 07/01/01
 Ending: 06/30/02

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	MARKETING SALARIES	(80,852)	43	1
2	MARKETING SUPPLIES	(12,764)	43	2
3	MARKETING OTHER EXPENSES	(36,285)	43	3
4	NURSING SUPPLIES- MISC,INC.	(2,110)	40	4
5	DEVELOP. EXP. ST. PAULS FOUNDATION	(91,802)	43	5
6	EXCESS PARTICIPATION	(425)	42	6
7	BAZAAR REV. - MISC,INC.	(370)	21	7
8	DEVELOPMENT SALARIES	(29,220)	43	8
9	GIFT SHOP REVENUE	(6,611)	21	9
10	RENTAL INCOME	(1,928)	21	10
11	COLLECTION EXPENSE	(10,999)	21	11
12	WEB ADVERTISING	(470)	21	12
13	BANK FEES	(23,347)	21	13
14	SENIOR FITNESS REVENUE	(12,285)	11	14
15	LEGAL INVOICE	(1,845)	19	15
16	SEMINAR EXP. NON-ALLOW.	(1,370)	24	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
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90				90
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92				92
93				93
94				94
95				95
96				96
97				97
98				98
99				99
100				100
101	Total	(553,815)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number ST PAULS HOUSE AND H C CTR# 0005165

Report Period Beginning:

07/01/01

Ending:

06/30/02

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													1
2	Food Purchase	(9,059)											(9,059)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities													5
6	Maintenance													6
7	Other (specify):*													7
8	TOTAL General Services	(9,059)											(9,059)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(2,119)											(2,119)	10
10a	Therapy													10a
11	Activities	(12,285)											(12,285)	11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	TOTAL Health Care and Programs	(14,404)											(14,404)	16
	C. General Administration													
17	Administrative													17
18	Directors Fees													18
19	Professional Services	(1,845)											(1,845)	19
20	Fees, Subscriptions & Promotions	(40,033)											(40,033)	20
21	Clerical & General Office Expenses	(163,516)	45										(163,471)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(1,370)											(1,370)	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice													26
27	Other (specify):*													27
28	TOTAL General Administration	(206,764)	45										(206,719)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(230,227)	45										(230,182)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number ST PAULS HOUSE AND H C CTR # 0005165 Report Period Beginning: 07/01/01 Ending: 06/30/02

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	85,737											85,737	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(13,377)	(58,736)										(72,113)	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds													34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*													36
37	TOTAL Ownership	72,360	(58,736)										13,624	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	(425)											(425)	42
43	Other (specify):*	(292,843)	91,802										(201,041)	43
44	TOTAL Special Cost Centers	(293,268)	91,802										(201,466)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(451,135)	33,111										(418,024)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
N/A		N/A		St Pauls Foundation	Chicago	Fund Raising

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	32 INVESTMENT INCOME	\$ 72,786	ST PAULS FOUNDATION	100.00%	\$	(72,786)	1
2	V	32 INVESTMENT MGMT FEES		ST PAULS FOUNDATION	100.00%	14,050	14,050	2
3	V	21 INVESTMENT BANK SERVICE		ST PAULS FOUNDATION	100.00%	45	45	3
4	V	43 DEVELOPMENT EXPENSES		ST PAULS FOUNDATION	100.00%	91,802	91,802	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		\$ 72,786			\$ 105,897	\$ * 33,111	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. 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)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. 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)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. 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)	
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. 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)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. 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)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. 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)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. 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)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. 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)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. 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)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

Facility Name & ID Number ST PAULS HOUSE AND H C CTR # 0005165 Report Period Beginning: 07/01/01 Ending: 06/30/02

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ST PAULS HOUSE AND H C CTR

0005165

Report Period Beginning: 07/01/01

Ending: 06/30/02

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 ST PAUL FOUNDATION
 Street Address 3800 N California
 City / State / Zip Code Chicago, Illinois 60618
 Phone Number (773) 478-4222
 Fax Number (773) 478-4516

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	32	INVESTMENT MGMT FEES	Direct Cost 1	1	14,050		1	14,050	2
3	21	INVEST. BANK SERVICE	Direct Cost 1	1	45		1	45	3
4	43	DEVELOPMENT EXPENSES	Direct Cost 1	1	91,802		1	91,802	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				\$ 105,897	\$		\$ 105,897	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ST PAULS HOUSE AND H C CTR

0005165

Report Period Beginning: 07/01/01

Ending: 06/30/02

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 _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ST PAULS HOUSE AND H C CTR

0005165

Report Period Beginning:

07/01/01

Ending: 06/30/02

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 _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ST PAULS HOUSE AND H C CTR

0005165

Report Period Beginning: 07/01/01

Ending: 06/30/02

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 _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ST PAULS HOUSE AND H C CTR

0005165

Report Period Beginning: 07/01/01

Ending: 06/30/02

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 _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ST PAULS HOUSE AND H C CTR

0005165

Report Period Beginning: 07/01/01

Ending: 06/30/02

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 _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ST PAULS HOUSE AND H C CTR

0005165

Report Period Beginning: 07/01/01

Ending: 06/30/02

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 _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ST PAULS HOUSE AND H C CTR

0005165

Report Period Beginning: 07/01/01

Ending: 06/30/02

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 _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ST PAULS HOUSE AND H C CTR

0005165

Report Period Beginning: 07/01/01

Ending: 06/30/02

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 _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ST PAULS HOUSE AND H C CTR

0005165

Report Period Beginning: 07/01/01

Ending: 06/30/02

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 _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ST PAULS HOUSE AND H C CTR # 0005165 Report Period Beginning: 07/01/01 Ending: 06/30/02

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	BOND DEBENTURE		X	Source of funds	none	06/96	\$ 6,500,000	\$ 5,885,000	02/01/25	Variable	\$ 115,446	1								
2	DEBENTURE BONDS		X	Source of funds	none	Various	70,500	32,300	Various	7.0000	2,261	2								
3												3								
4												4								
5												5								
Working Capital																				
6	LETTER OF CREDIT		X								31,117	6								
7												7								
8												8								
9	TOTAL Facility Related						\$ 6,570,500	\$ 5,917,300			\$ 148,824	9								
B. Non-Facility Related*																				
10	See Supplemental Schedule							784,674			30,566	10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$ 784,674			\$ 30,566	14								
15	TOTALS (line 9+line14)						\$ 6,570,500	\$ 6,701,974			\$ 179,390	15								

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

* 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' COMPILATION REPORT

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME ST PAULS HOUSE AND H C CTR COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0005165

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2001 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 2001.

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

B. Real Estate Tax Cost Allocations

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

If YES, attach an explanation & 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 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME ST PAULS HOUSE AND H C CTR COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0005165

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 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 2000.

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

B. Real Estate Tax Cost Allocations

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

If YES, attach an explanation & 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 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number ST PAULS HOUSE AND H C CTR

0005165 Report Period Beginning:

07/01/01 Ending:

06/30/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 91,138 B. General Construction Type: Exterior BRICK Frame N/A 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, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).
St Pauls Residence - 2815 W, Baron - Chicago, IL 60618

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

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

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>FACILITY</u>		<u>1910</u>	<u>\$ 103,080</u>	1
2					2
3	TOTALS			\$ 103,080	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4			1986	\$ 3,871,467	\$	35	\$ 193,573	\$ 193,573	\$ 2,645,499	4
5			1974	1,284,322		35	42,811	42,811	797,794	5
6			1949	332,671		35			328,168	6
7			1980	3,941		35				7
8										8
Improvement Type**										
9	Various		1976	27,003		20	-		-	9
10	Various		1978	751,898		20	-		735,926	10
11	Various		1981	74,417		20	-		74,417	11
12	Various		1982	88,065		20	8	8	87,890	12
13	Various		1984	21,915		20	-		21,915	13
14	Various		1985	235,600		20	7,558	7,558	218,857	14
15	Various		1986	99,966		20	2,788	2,788	77,380	15
16	Various		1987	17,045		20	711	711	7,409	16
17	Various		1988	1,500		20	-		1,500	17
18	Various		1989	5,140		20	-		5,140	18
19	Various		1990	58,255		20	2,913	2,913	36,412	19
20	Various		1991	7,167		20	425	425	2,662	20
21	Various		1992	48,661		20	2,366	2,366	9,223	21
22	Various		1994	15,410		20	1,076	1,076	8,916	22
23	Various		1995	8,236		20	413	413	2,863	23
24	Various		1996	244,921		20	12,247	12,247	29,479	24
25	Various		1997	5,967,238		20	202,115	202,115	1,151,721	25
26	Various		1998	95,528		20	8,862	8,862	33,556	26
27							-		-	27
28							-		-	28
29							-		-	29
30							-		-	30
31							-		-	31
32							-		-	32
33							-		-	33
34							-		-	34
35							-		-	35
36							-		-	36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$ -	\$	\$ -	37
38					-		-	38
39					-		-	39
40					-		-	40
41					-		-	41
42					-		-	42
43					-		-	43
44					-		-	44
45					-		-	45
46					-		-	46
47					-		-	47
48					-		-	48
49					-		-	49
50					-		-	50
51					-		-	51
52					-		-	52
53					-		-	53
54					-		-	54
55					-		-	55
56					-		-	56
57					-		-	57
58					-		-	58
59					-		-	59
60					-		-	60
61					-		-	61
62					-		-	62
63					-		-	63
64					-		-	64
65					-		-	65
66					-		-	66
67					-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)							68
69	Financial Statement Depreciation				557,689		(557,689)	69
70	TOTAL (lines 4 thru 69)		\$ 13,260,366	\$ 557,689		\$ 477,866	\$ (79,823)	\$ 6,276,727 70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number ST PAULS HOUSE AND H C CTR

0005165

Report Period Beginning:

07/01/01

Ending:

06/30/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	
1	Totals from Page 12A, Carried Forward		\$ 13,260,366	\$ 557,689		\$ 477,866	\$ (79,823)	\$ 6,276,727	1
2	DAMPER AIR COMPRESSO	1999	292		20	15	15	51	2
3	INSPECTION DOORS	1999	1,240		20	62	62	217	3
4	PUMP MATERIALS	1999	381		20	19	19	67	4
5	SMOKE DAMPERS	1999	20,380		20	1,019	1,019	3,482	5
6	SMOKE/FIRE DAMPERS	1999	708		20	35	35	120	6
7	FIRE DAMPER ACTIVATO	1999	195		20	10	10	33	7
8	SMOKE DAMPER CONSULT	1999	367		20	18	18	62	8
9	PH SYSTEM, SPEAKERS	1999	4,250		20	850	850	2,904	9
10	P11 SYSTEM, TAPE DRI	1999	6,971		20	1,394	1,394	4,879	10
11	P11 SYSTEM, OFFICE 9	1999	4,251		20	850	850	2,904	11
12	CARPENTRY REPAIRS	1999	11,075		20	554	554	1,431	12
13	REPAIR	1999	1,200		20	60	60	180	13
14	FIREPROOFING	1999	4,000		20	200	200	600	14
15	INSTALL DOOR	1999	2,098		20	105	105	306	15
16	DOOR CLOSURES	1999	7,531		20	377	377	1,005	16
17	DOOR CLOSURES	1999	1,833		20	92	92	245	17
18	DOOR CLOSURES	1999	1,460		20	73	73	195	18
19	DOOR CLOSURES	1999	945		20	47	47	121	19
20	INSTALL CARPET	1999	780		20	39	39	101	20
21	INSTALL TILE	1999	688		20	34	34	88	21
22	RAILINGS	1999	1,766		20	88	88	242	22
23	CAST IRON	1999	800		20	40	40	113	23
24	DRAIN COVERS	1999	1,216		20	61	61	173	24
25	DRYWALL REPAIR & PNT	1999	11,725		20	586	586	1,563	25
26	DOORS	1999	10,680		20	534	534	1,424	26
27	DRYWALL REPAIR & PNT	1999	10,615		20	531	531	1,416	27
28	DRYWALL REPAIR & PNT	1999	12,298		20	615	615	1,589	28
29	PLASTIC LUMBER	1999	1,421		20	71	71	183	29
30	AIR HANDLER	1999	1,067		20	53	53	146	30
31	DOORS	1999	787		20	39	39	101	31
32	PIPING	1999	3,682		20	184	184	491	32
33	BOILER REPAIR	1999	951		20	48	48	124	33
34	TOTAL (lines 1 thru 33)		\$ 13,388,019	\$ 557,689		\$ 486,569	\$ (71,120)	\$ 6,303,283	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number ST PAULS HOUSE AND H C CTR

0005165

Report Period Beginning:

07/01/01

Ending:

06/30/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	
1	Totals from Page 12B, Carried Forward		\$ 13,388,019	\$ 557,689		\$ 486,569	\$ (71,120)	\$ 6,303,283	1
2	DRAPERIES	1999	3,012		20	151	151	453	2
3	PAINT/DECOR	1999	9,850		20	493	493	1,356	3
4	ROOFING	1999	7,612		20	381	381	1,016	4
5	FOUNDATION STUDY	2000	4,300		20	215	215	538	5
6	HALLWAY REPAIR	2000	6,219		20	311	311	648	6
7	ELEV REMODELING	2000	7,890		20	395	395	823	7
8	INSTALL CARPET	2000	420		20	21	21	53	8
9	INSTALL CARPET	2000	120		20	6	6	14	9
10	INSTALL CARPET	2000	120		20	6	6	15	10
11	RAILINGS	2000	903		20	45	45	113	11
12	HEAT/COOL CONTROL	2000	554		20	28	28	70	12
13	SOLENOID VALVE	2000	1,048		20	52	52	130	13
14	ELECTRIC STARTER MOT	2000	978		20	49	49	110	14
15	AIR DIVERTERS & SCRNS	2000	1,423		20	71	71	154	15
16	VALVES & GRATES	2000	1,865		20	93	93	202	16
17	CARPET	2000	640		20	32	32	69	17
18	BOILER TUBES	2000	324		20	16	16	40	18
19	BOILER TUBES	2000	9,628		20	481	481	1,162	19
20	SHADES	2000	11,434		20	572	572	1,430	20
21	BLINDS	2000	1,514		20	76	76	158	21
22	PLUM INSTALLATION	2000	7,900		20	395	395	823	22
23	SENIOR FITNESS CNTR	2000	1,775		20	89	89	148	23
24	SEWER	2000	5,330		20	267	267	445	24
25	SHOWER STALLS	2000	5,089		20	254	254	402	25
26	SOIL TESTS	2000	2,321		20	116	116	222	26
27	SHOWER	2000	675		20	34	34	68	27
28	BUILDING LOAN FEES	2000	5,601		20	280	280	513	28
29	FLOORING	2000	1,880		20	94	94	165	29
30	FLOORING	2000	580		20	29	29	48	30
31	ALARM SYSTEM	2000	1,612		20	81	81	142	31
32	HEATING PUMP	2000	1,549		20	77	77	154	32
33	DESIGN FEES	2000	2,269		20	113	113	198	33
34	TOTAL (lines 1 thru 33)		\$ 13,494,454	\$ 557,689		\$ 491,892	\$ (65,797)	\$ 6,315,165	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number ST PAULS HOUSE AND H C CTR

0005165

Report Period Beginning:

07/01/01

Ending:

06/30/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	
1	Totals from Page 12C, Carried Forward		\$ 13,494,454	\$ 557,689		\$ 491,892	\$ (65,797)	\$ 6,315,165	1
2	WINDOW TREATMENTS	2000	1,400		20	70	70	128	2
3	WINDOW TREATMENTS	2000	1,318		20	66	66	110	3
4	WINDOW TREATMENTS	2000	487		20	24	24	38	4
5	SENIOR FITNESS CNTR	2001	1,729		20	86	86	122	5
6	SHOWER VALVES	2001	1,811		20	91	91	137	6
7	SHOWER WALL	2001	1,681		20	84	84	119	7
8	ARCHITECT FEES	2001	202		20	10	10	13	8
9	ARCHITECT FEES	2001	3,299		20	165	165	206	9
10	ARCHITECT FEES	2001	195		20	10	10	13	10
11	ARCHITECT FEES	2001	3,249		20	162	162	203	11
12	ARCHITECT FEES	2001	263		20	13	13	16	12
13	ARCHITECT FEES	2001	5,130		20	257	257	321	13
14	ARCHITECT FEES	2001	2,722		20	136	136	170	14
15	ARCHITECT FEES	2001	133		20	7	7	9	15
16	ARCHITECT FEES	2001	133		20	7	7	9	16
17	ARCHITECT FEES	2001	3,782		20	189	189	236	17
18	ARCHITECT FEES	2001	1,937		20	97	97	121	18
19	ARCHITECT FEES	2001	18		20	1	1	1	19
20	LOBBY CONSTRUCTION	2001	28,653		20	1,433	1,433	1,791	20
21	LOBBY CONSTRUCTION	2001	32,251		20	1,613	1,613	2,016	21
22	LOBBY CONSTRUCTION	2001	373,492		20	18,675	18,675	23,344	22
23	LOBBY CONSTRUCTION	2001	361,732		20	18,087	18,087	22,609	23
24	LOBBY CONSTRUCTION	2001	9,800		20	490	490	613	24
25	LOBBY CONSTRUCTION	2001	208,677		20	10,434	10,434	13,043	25
26	LOBBY CONSTRUCTION	2001	354,938		20	17,747	17,747	22,184	26
27	DESIGN FEES	2001	41		20	2	2	3	27
28	BUILDERS INS	2001	1,500		20	75	75	94	28
29	BUILDERS INS	2001	1,500		20	75	75	94	29
30	AFFILIATED CUSTOMER	2001	698		20	35	35	44	30
31	ARCHITECT FEES	2001	5,624		20	281	281	351	31
32	ARCHITECT FEES	2001	13,843		20	692	692	865	32
33	ARCHITECT FEES	2001	3,164		20	158	158	198	33
34	TOTAL (lines 1 thru 33)		\$ 14,919,856	\$ 557,689		\$ 563,164	\$ 5,475	\$ 6,404,386	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number ST PAULS HOUSE AND H C CTR

0005165

Report Period Beginning:

07/01/01

Ending:

06/30/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	
1	Totals from Page 12D, Carried Forward		\$ 14,919,856	\$ 557,689		\$ 563,164	\$ 5,475	\$ 6,404,386	1
2	ARCHITECT FEES	2001	590		20	30	30	38	2
3	ARCHITECT FEES	2001	18,034		20	902	902	1,128	3
4	ARCHITECT FEES	2001	113		20	6	6	8	4
5	ARCHITECT FEES	2001	12,342		20	617	617	771	5
6	ARCHITECT FEES	2001	34,480		20	1,724	1,724	2,155	6
7	ARCHITECT FEES	2001	2,947		20	147	147	184	7
8	ARCHITECT FEES	2001	2,866		20	143	143	179	8
9	ARCHITECT FEES	2001	43		20	2	2	3	9
10	ARCHITECT FEES	2001	40		20	2	2	3	10
11	ARCHITECT FEES	2001	170		20	9	9	11	11
12	ARCHITECT FEES	2001	812		20	41	41	51	12
13	ARCHITECT FEES	2001	1,200		20	60	60	75	13
14	BUILDING INSURANCE	2001	6,650		20	333	333	416	14
15	SENIOR FITNESS CTR	2001	762		20	38	38	67	15
16	SENIOR FITNESS CTR	2001	1,094		20	55	55	96	16
17	SENIOR FITNESS CTR	2001	255		20	13	13	23	17
18	SENIOR FITNESS CTR	2001	4,290		20	215	215	233	18
19	SENIOR FITNESS CTR	2001	676		20	34	34	54	19
20	FLOORING	2001	1,898		20	95	95	111	20
21	CONSTR INTEREST	2001	33,414		20	1,671	1,671	2,089	21
22	INTERCOM SYSTEM	2001	5,488		20	274	274	411	22
23	PAGE SYSTEM	2001	4,990		20	250	250	354	23
24	IDENTICARD 9000	2001	4,806		20	240	240	300	24
25	ELECTRIC STRIKE	2001	545		20	27	27	32	25
26	DOORS	2001	2,995		20	150	150	175	26
27	DOOR CLOSERS	2001	3,625		20	181	181	211	27
28	A/C UPGRADE	2001	4,699		20	215	215	215	28
29	DUCT WORK	2001	4,864		20	142	142	142	29
30	VOLTAGE REGULATOR	2001	935		20	27	27	27	30
31	ELEVATOR PUMP	2001	1,277		20	37	37	37	31
32	KITCHEN FLOOR	2001	2,880		20	96	96	96	32
33	BUILDING SURVEY	2001	667		20	33	33	33	33
34	TOTAL (lines 1 thru 33)		\$ 15,080,303	\$ 557,689		\$ 570,973	\$ 13,284	\$ 6,414,114	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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 12E, Carried Forward		\$ 15,080,303	\$ 557,689		\$ 570,973	\$ 13,284	\$ 6,414,114	1
2	GENERATOR	2002	1,907		20	40	40	40	2
3	PLUMBING	2002	1,346		20	34	34	34	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
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 15,083,556	\$ 557,689		\$ 571,047	\$ 13,358	\$ 6,414,188	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	
1	Totals from Page 12F, Carried Forward		\$ 15,083,556	\$ 557,689		\$ 571,047	\$ 13,358	\$ 6,414,188	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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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 15,083,556	\$ 557,689		\$ 571,047	\$ 13,358	\$ 6,414,188	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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 12G, Carried Forward		\$ 15,083,556	\$ 557,689		\$ 571,047	\$ 13,358	\$ 6,414,188	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 15,083,556	\$ 557,689		\$ 571,047	\$ 13,358	\$ 6,414,188	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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 12H, Carried Forward		\$ 15,083,556	\$ 557,689		\$ 571,047	\$ 13,358	\$ 6,414,188	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 15,083,556	\$ 557,689		\$ 571,047	\$ 13,358	\$ 6,414,188	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number **ST PAULS HOUSE AND H C CTR**

0005165

Report Period Beginning:

07/01/01

Ending:

06/30/02

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*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-REP, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

	1	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$	\$		\$	\$	\$	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 1,408,122	\$	\$ 68,375	\$ 68,375	10	\$ 1,150,455	71
72	Current Year Purchases	28,590		4,004	4,004	10	3,209	72
73	Fully Depreciated Assets	652,877				10	652,877	73
74								74
75	TOTALS	\$ 2,089,589	\$	\$ 72,379	\$ 72,379		\$ 1,806,541	75

D. Vehicle Depreciation (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		VAN	1994	\$ 37,650	\$	\$	\$	5	\$ 37,650	76
77										77
78										78
79										79
80	TOTALS			\$ 37,650	\$	\$	\$		\$ 37,650	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)	\$ 17,313,875	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 557,689	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 643,426	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 85,737	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 8,258,379	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.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions.

YES NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	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: \$ 40,045 Description: Savin Copier \$22,481 - Postage Meter \$3,201 - Ricoh Copier \$8,016 - Achieve \$4,541- Others \$1,806

(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. /2003 \$ _____

13. /2004 \$ _____

14. /2005 \$ _____

* 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.

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		Contract	Total
		1 Drop-outs	2 Completed		
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	Nurse Aide 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 aides from other facilities.

\$ _____

D. NUMBER OF AIDES 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 aide 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 aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides 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 aides.
- SEE ACCOUNTANTS' COMPILATION REPORT

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5	6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Staff		Outside Practitioner (other than consultant)								
			Units of Service	Cost	Units	Cost							
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$	191,623	\$			\$	191,623	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				8,182					8,182	2
3	Licensed Recreational Therapist		hrs										3
4	Licensed Physical Therapist	39 - 03	hrs				386,538					386,538	4
5	Physician Care		visits										5
6	Dental Care		visits										6
7	Work Related Program		hrs										7
8	Habilitation		hrs										8
9	Pharmacy	39 - 02	# of prescripts						517,699			517,699	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs										10
11	Academic Education		hrs										11
12	Exceptional Care Program												12
13	Other (specify): See Supplemental						3,416		41,242			44,658	13
14	TOTAL			\$		\$	589,759	\$	558,941		\$	1,148,700	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 nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ST PAULS HOUSE AND H C CTR

0005165

Report Period Beginning: 07/01/01

Ending:

06/30/02

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/02

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 11,376	\$	1
2	Cash-Patient Deposits	124,734		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,758,277		3
4	Supply Inventory (priced at)	42,223		4
5	Short-Term Investments			5
6	Prepaid Insurance	45,784		6
7	Other Prepaid Expenses	14,514		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Supplemental Schedule	18,123		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,015,031	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	103,081		13
14	Buildings, at Historical Cost	15,039,070		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,256,895		16
17	Accumulated Depreciation (book methods)	(7,690,012)		17
18	Deferred Charges	294,697		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): See Supplemental Schedule	73,017		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 10,076,748	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 12,091,779	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,036,872	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	182,010		28
29	Short-Term Notes Payable	951,974		29
30	Accrued Salaries Payable	375,880		30
31	Accrued Taxes Payable (excluding real estate taxes)	12,288		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	28,571		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Supplemental Schedule			36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,587,595	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	5,750,000		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Supplemental Schedule			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 5,750,000	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 8,337,595	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,754,184	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 12,091,779	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 4,345,570	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 4,345,570	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(591,386)	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)	\$ (591,386)	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)	\$ 3,754,184	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

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	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 7,047,567	1
2	Discounts and Allowances for all Levels	(241,908)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,805,659	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,043,242	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,043,242	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	6,611	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	9,059	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	1,928	16
17	Sale of Drugs	447,267	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	24,940	19
20	Radiology and X-Ray	5,365	20
21	Other Medical Services	353,146	21
22	Laundry	26,557	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 874,873	23
D. Non-Operating Revenue			
24	Contributions	119,815	24
25	Interest and Other Investment Income***	13,377	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 133,192	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	30,669	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 30,669	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,887,635	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,970,990	31
32	Health Care	3,131,954	32
33	General Administration	2,086,469	33
B. Capital Expense			
34	Ownership	862,245	34
C. Ancillary Expense			
35	Special Cost Centers	1,349,741	35
36	Provider Participation Fee	77,622	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,479,021	40
41	Income before Income Taxes (line 30 minus line 40)**	(591,386)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (591,386)	43

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

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

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

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

Facility Name & ID Number ST PAULS HOUSE AND H C CTR

0005165

Report Period Beginning:

07/01/01

Ending:

06/30/02

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	1,884	2,150	\$ 74,106	\$ 34.47	1
2	Assistant Director of Nursing	2,007	2,239	74,191	33.14	2
3	Registered Nurses	25,750	33,171	879,822	26.52	3
4	Licensed Practical Nurses	9,857	10,604	173,098	16.32	4
5	Nurse Aides & Orderlies	78,580	94,074	889,677	9.46	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,243	2,328	42,048	18.06	9
10	Activity Assistants	7,730	8,378	77,252	9.22	10
11	Social Service Workers	11,671	13,222	258,336	19.54	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	7,518	8,369	93,081	11.12	15
16	Dishwashers	29,417	32,166	237,841	7.39	16
17	Maintenance Workers	13,696	15,893	184,365	11.60	17
18	Housekeepers	16,241	19,051	150,503	7.90	18
19	Laundry	6,870	7,851	58,794	7.49	19
20	Administrator	1,480	1,984	122,773	61.88	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	18,735	22,844	376,883	16.50	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	2,084	2,249	21,675	9.64	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	5,748	8,465	110,072	13.00	33
34	TOTAL (lines 1 - 33)	241,511	285,038	\$ 3,824,517 *	\$ 13.42	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	4,768	\$ 73,889	01-03	35
36	Medical Director	Monthly	10,000	09-03	36
37	Medical Records Consultant	1,005	13,258	10-03	37
38	Nurse Consultant	2,740	6,410	10-03	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	3,048	76,201	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Fee	400	11-03	44
45	Social Service Consultant	Fee	4,865	12-03	45
46	Other(specify)				46
47	<u>HDS MGMT FEES DIETARY</u>	Fee	109,743	01-03	47
48					48
49	TOTAL (lines 35 - 48)	11,561	\$ 294,766		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	6,435	\$ 267,378	10-03	50
51	Licensed Practical Nurses	1,428	45,048	10-03	51
52	Nurse Aides	200	4,070	10-03	52
53	TOTAL (lines 50 - 52)	8,063	\$ 316,496		53

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Lawrence D. Carlson	Exe. Director	0	\$ 122,773	Workers' Compensation Insurance	\$ 65,478	IDPH License Fee	\$	
7.1.01-4.6.02				Unemployment Compensation Insurance	46,230	Advertising: Employee Recruitment	9,638	
				FICA Taxes	292,576	Health Care Worker Background Check		
				Employee Health Insurance	229,306	(Indicate # of checks performed)	1,070	
				Employee Meals	11,373	Dues & Subscriptions	28,282	
				Illinois Municipal Retirement Fund (IMRF)*	100,334	Life Services	7,551	
						Yellow Pages	6,445	
						Public Relations	40,033	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 122,773					
(List each licensed administrator separately.)								
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
			\$			\$	Out-of-State Travel	\$
							In-State Travel	
							Seminar Expense	6,587
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL		\$	Entertainment Expense	()
(Attach a copy of any management service agreement)				(agree to Sch. V, line 24, col. 8)			TOTAL	\$ 6,587
C. Professional Services								
Vendor/Payee	Type	Amount						
FR&R	Accounting/Consulting	\$ 68,790						
Various - See Attached Sched.	Legal	13,109						
Automatic Data Processing	Payroll Processing	15,885						
Various - See Attached Sched.	Administrative	234,385						
TOTAL (agree to Schedule V, line 19, column 3)			\$ 332,169					
(If total legal fees exceed \$2500 attach copy of invoices.)								

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	N/A	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ST PAULS HOUSE AND H C CTR

0005165

Report Period Beginning:

07/01/01

Ending:

06/30/02

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. LSN - \$7,551
- (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? _____
- (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? _____
- (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. \$ 64,366 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. _____
- (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.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 77,197
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.

SEE ACCOUNTANTS' COMPILATION REPORT
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, 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? NO 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. \$ 11,373 Has any meal income been offset against related costs? YES Indicate the amount. \$ 9,059
- (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. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 100%ln14
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? N/A
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. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: FROST, RUTTENBERG & ROTHBLATT The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? NO If no, please explain. Will forward when completed
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees