



Facility Name & ID Number St Paul's Home

# 0013920 Report Period Beginning: 01/01/05 Ending: 12/31/05

**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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	<u>113</u>	Intermediate (ICF)	<u>113</u>	<u>41,245</u>	3
4		Intermediate/DD			4
5	<u>62</u>	Sheltered Care (SC)	<u>62</u>	<u>22,630</u>	5
6		ICF/DD 16 or Less			6
7	<u>175</u>	TOTALS	<u>175</u>	<u>63,875</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		2 Medicaid Recipient	3 Private Pay	4 Other		
8	SNF					8
9	SNF/PED					9
10	ICF	<u>19,619</u>	<u>14,710</u>		<u>34,329</u>	10
11	ICF/DD					11
12	SC	<u>2,746</u>	<u>4,674</u>		<u>7,420</u>	12
13	DD 16 OR LESS					13
14	TOTALS	<u>22,365</u>	<u>19,384</u>		<u>41,749</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 65.36%

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)  
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?  
YES  NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?  
YES  NO

I. On what date did you start providing long term care at this location?  
Date started 1926

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date \_\_\_\_\_ NO

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

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

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/05 Fiscal Year: 12/31/05

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

STATE OF ILLINOIS

Facility Name & ID Number St Paul's Home # 0013920 Report Period Beginning: 01/01/05 Ending: 12/31/05

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

	Operating Expenses	Costs Per General Ledger				Reclassification 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
<b>A. General Services</b>											
1	Dietary	266,964	28,486	6,273	301,723		301,723	301,723			1
2	Food Purchase		196,906		196,906		196,906	196,906			2
3	Housekeeping	177,052	27,920		204,972		204,972	204,972			3
4	Laundry	80,382	9,269		89,651		89,651	89,651			4
5	Heat and Other Utilities			218,111	218,111		218,111	218,111			5
6	Maintenance	75,831	43,644	13,793	133,268		133,268	133,268			6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	<b>600,229</b>	<b>306,225</b>	<b>238,177</b>	<b>1,144,631</b>		<b>1,144,631</b>	<b>1,144,631</b>			<b>8</b>
<b>B. Health Care and Programs</b>											
9	Medical Director			9,161	9,161		9,161	9,161			9
10	Nursing and Medical Records	1,453,111	29,881	7,814	1,490,806		1,490,806	1,490,806			10
10a	Therapy	20,820		7,134	27,954		27,954	27,954			10a
11	Activities	50,912	2,696	791	54,399		54,399	54,399			11
12	Social Services	48,514			48,514		48,514	48,514			12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>1,573,357</b>	<b>32,577</b>	<b>24,900</b>	<b>1,630,834</b>		<b>1,630,834</b>	<b>1,630,834</b>			<b>16</b>
<b>C. General Administration</b>											
17	Administrative	69,746		182,979	252,725		252,725	252,725			17
18	Directors Fees										18
19	Professional Services			35,002	35,002		35,002	35,002			19
20	Dues, Fees, Subscriptions & Promotions			24,569	24,569		24,569	(9,868)	14,701		20
21	Clerical & General Office Expenses	139,405	22,776	9,950	172,131		172,131	172,131			21
22	Employee Benefits & Payroll Taxes			536,732	536,732		536,732	536,732			22
23	Inservice Training & Education										23
24	Travel and Seminar			1,520	1,520		1,520	1,520			24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			140,028	140,028		140,028	140,028			26
27	Other (specify):*			22,658	22,658		22,658	(22,658)			27
28	<b>TOTAL General Administration</b>	<b>209,151</b>	<b>22,776</b>	<b>953,438</b>	<b>1,185,365</b>		<b>1,185,365</b>	<b>(32,526)</b>	<b>1,152,839</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>2,382,737</b>	<b>361,578</b>	<b>1,216,515</b>	<b>3,960,830</b>		<b>3,960,830</b>	<b>(32,526)</b>	<b>3,928,304</b>		<b>29</b>

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

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

Facility Name &amp; ID Number

St Paul's Home

#0013920

Report Period Beginning:

01/01/05

Ending:

12/31/05

## 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	
	<b>D. Ownership</b>											
30	Depreciation			194,182	194,182		194,182	194,182				30
31	Amortization of Pre-Op. & Org.											31
32	Interest			76,634	76,634		76,634	76,634				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			270,816	270,816		270,816	270,816				37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation			2,678	2,678		2,678	2,678				38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			61,868	61,868		61,868	61,868				42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			64,546	64,546		64,546	64,546				44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,382,737	361,578	1,551,877	4,296,192		4,296,192	(32,526)	4,263,666			45

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

**VI. ADJUSTMENT DETAIL**

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

		1	2	3	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>OHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				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				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	9,868	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	22,658	27		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ 32,526		\$	30

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

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

		1	2	
		<b>Amount</b>	<b>Reference</b>	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ 32,526		37

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

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

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

St Paul's Home

ID# 0013920

Report Period Beginning: 01/01/05

Ending: 12/31/05

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Bank Charges	\$ 601	27	1
2	Miscellaneous Sundry Items	5,347	27	2
3	Fines and Penalties	5,000	27	3
4	Compliance Ad Cost	28	27	4
5	Catawba Property Expense	7,372	27	5
6	Krummrich Property Expense	4,310	27	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	22,658		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number St Paul's Home

# 0013920

Report Period Beginning:

01/01/05

Ending:

12/31/05

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	0	0	0	0	0	0	0	0	0	0	0	0	8
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	0	0	0	0	0	0	0	0	0	0	0	0	16
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	9,868	0	0	0	0	0	0	0	0	0	0	9,868	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	22,658	0	0	0	0	0	0	0	0	0	0	22,658	27
28	<b>TOTAL General Administration</b>	32,526	0	0	0	0	0	0	0	0	0	0	32,526	28
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	32,526	0	0	0	0	0	0	0	0	0	0	32,526	29



Facility Name & ID Number St Paul's Home

# 0013920

Report Period Beginning:

01/01/05

Ending:

12/31/05

**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
<a href="#">See Attached Schedule page 26</a>						

**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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	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	<b>Total</b>		\$			\$	\$ *	14

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

Facility Name & ID Number      St Paul's Home      #      0013920      Report Period Beginning:      01/01/05      Ending:      12/31/05

## 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	NONE								\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

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

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

Facility Name & ID Number St Paul's Home # 0013920 Report Period Beginning: 01/01/05 Ending: 12/31/05

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

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

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

Facility Name & ID Number St Paul's Home # 0013920 Report Period Beginning: 01/01/05 Ending: 12/31/05

**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	
						Original	Balance					
	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									
<b>A. Directly Facility Related</b>												
<b>Long-Term</b>												
1	Regions Bank		X	Real Estate Mortgage	\$5,486.00	12/15/00	\$ 636,144	\$ 552,804	12/13/2006	7.0600	\$ 26,324	1
2	Regions Bank		X	Real Estate Mortgage	\$540.00	06/15/01	59,498	48,990	12/13/2006	7.0600	3,128	2
3												3
4												4
5												5
<b>Working Capital</b>												
6	Regions Bank		X	Provide Operating Funds		07/05/04	210,000		07/05/2005	6.0000	5,340	6
7	Regions Bank		X	Provide Operating Funds		07/05/05	210,000	209,000	07/05/2006	7.5000	7,235	7
8	St. Paul's Foundation	X		Provide Operating Funds		01/01/05	917,500	1,248,500	01/01/2006	3.0000	34,607	8
9	<b>TOTAL Facility Related</b>				\$6,026.00		\$ 2,033,142	\$ 2,059,294			\$ 76,634	9
<b>B. Non-Facility Related*</b>												
10												10
11												11
12												12
13												13
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14
15	<b>TOTALS (line 9+line14)</b>						\$ 2,033,142	\$ 2,059,294			\$ 76,634	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.)

\*\* 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**

<p><b>Important</b>, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>																							
1. Real Estate Tax accrual used on 2004 report.		\$	<b>Exempt</b> 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).		\$	<b>Exempt</b> 3																				
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	4																				
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	5																				
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	6																				
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>Exempt</b> 7																				
Real Estate Tax History:																							
Real Estate Tax Bill for Calendar Year:	<table border="1"> <tr><td>2000</td><td>8</td></tr> <tr><td>2001</td><td>9</td></tr> <tr><td>2002</td><td>10</td></tr> <tr><td>2003</td><td>11</td></tr> <tr><td>2004</td><td>12</td></tr> </table>	2000	8	2001	9	2002	10	2003	11	2004	12	<table border="1"> <tr><td colspan="2"><b>FOR OHF USE ONLY</b></td></tr> <tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2004 \$</td></tr> <tr><td>14</td><td>PLUS APPEAL COST FROM LINE 5 \$</td></tr> <tr><td>15</td><td>LESS REFUND FROM LINE 6 \$</td></tr> <tr><td>16</td><td>AMOUNT TO USE FOR RATE CALCULATION \$</td></tr> </table>	<b>FOR OHF USE ONLY</b>		13	FROM R. E. TAX STATEMENT FOR 2004 \$	14	PLUS APPEAL COST FROM LINE 5 \$	15	LESS REFUND FROM LINE 6 \$	16	AMOUNT TO USE FOR RATE CALCULATION \$	
2000	8																						
2001	9																						
2002	10																						
2003	11																						
2004	12																						
<b>FOR OHF USE ONLY</b>																							
13	FROM R. E. TAX STATEMENT FOR 2004 \$																						
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.**

**IMPORTANT NOTICE**

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2004 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 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 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,

**2004 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME St Paul's Home COUNTY St. Clair

FACILITY IDPH LICENSE NUMBER 0013920

CONTACT PERSON REGARDING THIS REPORT \_\_\_\_\_

TELEPHONE ( ) \_\_\_\_\_ FAX #: ( ) \_\_\_\_\_

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

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 2004

(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. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ _____	\$ _____

**B. Real Estate Tax Cost Allocation:**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct 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 hom (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 2004 tax bills which were listed in Section A to this statement. Be sure to use the 200 tax bill which is normally paid during 2005

Facility Name &amp; ID Number St Paul's Home

# 0013920 Report Period Beginning:

01/01/05 Ending:

12/31/05

## X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 56,032 B. General Construction Type: Exterior Brick Frame \_\_\_\_\_ Number of Stories See Attached pg. 24C. 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 ground (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)

St. Paul's Home Retirement Community, independent living apartments, 62,500 square feet, 53 apartmentsF. 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	Resident Use	178,000	1926	\$ 16,901	1
2	Resident Use	Land Improvements	1995	5,310	2
3	TOTALS	#VALUE!		\$ 22,211	3

Facility Name &amp; ID Number St Paul's Home

# 0013920

Report Period Beginning:

01/01/05

Ending:

12/31/05

## 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	30	1960	1960	\$ 166,566	\$	25	\$	\$	\$ 166,566	4
5	32	1957	1957	148,250	2,968	50	2,968		142,326	5
6	38	1962	1962	266,977	13,760	50	13,760		239,458	6
7	75	1971	1971	654,498	15,997	40	15,997		567,580	7
8		1981	1981	718,105	16,833	40	16,833		451,576	8
<b>Improvement Type**</b>										
9		1961		14,618		25			14,618	9
10		1963		594		25			594	10
11		1971		40,791		25			40,791	11
12		1973		1,471		25			1,471	12
13		1974		1,162		20			1,162	13
14		1975		7,723		25			7,723	14
15		1976		75,275	2,015	35	2,015		64,195	15
16		1977		13,703		10			13,703	16
17		1978		24,680		25			24,680	17
18		1979		454,801	15,160	30	15,160		401,741	18
19		1980		5,908		20			5,908	19
20		1982		44,406		10			44,406	20
21		1983		6,581		10			6,581	21
22		1984		8,251		10			8,251	22
23		1985		2,786		10			2,783	23
24		1986		17,208	690	20	690		13,331	24
25		1987		169,475	3,972	20	3,972		143,156	25
26		1989		38,131		15			38,131	26
27		1991		109,995	4,664	20	4,664		82,955	27
28		1992		54,380	862	10	862		44,478	28
29		1993		6,300	252	25	252		3,276	29
30		1994		45,495	2,866	15	2,866		36,328	30
31		1995		21,589		10			21,589	31
32	Repaved parking lot / sidewalk improvement	1996		19,616	1,699	15	1,699		16,133	32
33	Dishroom renovation and door installation	1996		38,379	2,009	20	2,009		19,999	33
34	Remodeled administrative office area	1996		9,218	615	15	615		5,839	34
35	Installation of fences	1996		4,099	410	10	410		4,099	35
36	Supplemental lighting for parking lot	1997		1,225	82	10	82		736	36

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

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

See Page 12A, Line 70 for total

Facility Name &amp; ID Number St Paul's Home

# 0013920

Report Period Beginning:

01/01/05

Ending:

12/31/05

## 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		
37	Asphalt driveway improvements	1997	\$ 11,065	\$ 851	10	\$ 851	\$	\$ 9,787		37
38	Building for emergency generator	1997	33,000	1,000	33	1,000		9,000		38
39	Structural improvements to Kohl wing	1997	21,878	1,286	20	1,286		11,139		39
40	Installation of fences	1997	1,823	182	10	182		1,549		40
41	Telephone alcove and construction of wall divider	1997	3,690	246	15	246		2,214		41
42	Internal corridor doors	1997	4,118	410	10	410		3,708		42
43	Remodeling / redecorating of resident rooms / areas	1997	29,198	2,856	10	2,856		25,673		43
44	Aluminum ramps / brackets for porch area	1998	1,121		5			1,121		44
45	Tuckpointing / Caulking of retaining wall	1998	2,500	312	8	312		2,343		45
46	Soffitt / fascia installation	1998	13,194	660	20	660		4,948		46
47	Wallcovering (employee dining room and main corridor)	1998	2,765	277	10	277		2,213		47
48	Roof replacement (Kohl wing)	1998	31,078	2,179	10	2,179		16,344		48
49	Remodeling of shower room (Kohl wing)	1998	3,836	384	10	384		2,877		49
50	Roof repairs (Ludwig wing)	1998	1,620	162	10	162		1,215		50
51	Shelter nurses' station renovation	1999	7,194	719	10	719		5,035		51
52	Structural repairs to Kohl wing	1999	1,988	199	10	199		1,392		52
53	Shower stall and flooring replacements (Kohl wing)	1999	4,418	442	10	442		3,093		53
54	Panic hardware for Ludwig front door	1999	527		5			527		54
55	Bartel wing lighting	1999	5,034	503	10	503		3,272		55
56	Valves for domestic water line	1999	1,927	193	10	193		1,308		56
57	Water supply lines for cooling tower	1999	592	4	10	4		274		57
58	Chapel roof repairs	1999	3,025	302	10	302		1,966		58
59	Bartel wing soiled linen room remodeling	2000	7,860	524	15	524		3,144		59
60	Heater covers for entry main corridor	2000	1,209	121	10	121		665		60
61	Replacement of Bartel wing sewer line	2000	16,237	812	20	812		4,871		61
62	Kitchen lighting project	2001	13,493	675	20	675		3,374		62
63	Exit seeker system	2001	10,767	1,077	10	1,077		5,384		63
64	Ludwig wing sewer project	2001	12,719	636	20	636		2,862		64
65	Master antennae system (Bartel wing)	2001	2,149	215	10	215		967		65
66	Window project (Bartel wing)	2001	22,442	898	25	898		4,040		66
67	Laundry dedicated electrical circuit	2001	840	84	10	84		378		67
68	Fire and smoke doors in Bartel long hall	2002	3,292	219	15	219		878		68
69	Chapel roof repair	2002	25,974	2,597	10	2,597		10,389		69
70	TOTAL (lines 4 thru 69)		\$ 3,494,829	\$ 105,879		\$ 105,879	\$	\$ 2,784,113		70

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

Facility Name &amp; ID Number St Paul's Home

# 0013920

Report Period Beginning:

01/01/05

Ending:

12/31/05

## 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		\$ 3,494,829	\$ 105,879		\$ 105,879	\$	\$ 2,784,113	1
2									2
3	Chapel - electrical work	2002	3,450	345	10	345		1,380	3
4	Kitchen - A/C	2002	1,612	161	10	161		645	4
5	Kitchen - walk-in refrigerator unit	2002	2,740	274	10	274		1,096	5
6	Kitchen - water storage tank replacement	2002	5,145	257	20	257		1,029	6
7	Front entry and walk	2002	34,288	2,286	10	2,286		8,572	7
8	Chapel - A/C unit	2002	8,410	841	10	841		3,364	8
9	Kitchen - walk-in freezer replacement	2002	4,750	475	10	475		1,662	9
10	Kitchen range hood electrical shut down project	2003	2,269	151	15	151		454	10
11	Lamp posts	2003	955	57	15	57		178	11
12	Front walk project	2003	8,583	858	10	858		2,575	12
13	West drive project	2003	2,115	212	10	212		635	13
14	New floor tile and subfloor room 102 Kohl wing	2003	2,135	213	10	213		533	14
15	Install new metal door for dishroom	2003	1,708	171	10	171		427	15
16	Fresh air intake for laundry room	2003	5,893	589	10	589		1,473	16
17	Repair exterior wall of employee dining room	2003	8,303	830	10	830		2,076	17
18	Hot water plumbing project	2004	33,937	1,697	20	1,697		3,394	18
19	Install shower thresholds (Bartel)	2004	1,550	155	10	155		310	19
20	Repair /Replaster North & West walls in employee dining room	2004	3,291	329	10	329		658	20
21	wall guards for 12 resident rooms and handrail main hall	2004	1,313	131	10	131		263	21
22	patch walls, ceilings, around windows in resident rooms	2004	13,179	1,318	10	1,318		2,636	22
23	replace bad section of cast iron waste line	2004	862	86	10	86		172	23
24	install acoustical ceiling in room 209	2004	855	85	10	85		171	24
25	Kohl wing HVAC air handler heating system	2004	1,937	194	10	194		291	25
26	Kohl and Ludwig front walk project	2004	1,111	111	10	111		167	26
27	Sprinkler Head installed in office stairwell and workshop	2005	1,446	145	10	145		145	27
28	200 gallon water storage tank	2005	10,415	955	10	955		955	28
29	state architect survey consultation	2005	1,976	148	10	148		148	29
30	fire dampers and smoke drapers	2005	489	37	10	37		37	30
31	Ludwig roof	2005	49,368	3,291	10	3,291		3,291	31
32	Ludwig roof	2005	5,485	366	10	366		366	32
33	master antenna system on new roof	2005	1,075	72	10	72		72	33
34	TOTAL (lines 1 thru 33)		\$ 3,715,474	\$ 122,719		\$ 122,719	\$	\$ 2,823,288	34

\*\*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 12B, Carried Forward	\$ 3,715,474	\$ 122,719		\$ 122,719	\$	\$ 2,823,288		1
2	state architect survey consultation	2005 875	44	10	44		44		2
3	state architect survey consultation	2005 2,452	123	10	123		123		3
4	state architect survey consultation	2005 1,000	50	10	50		50		4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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22									22
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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)	\$ 3,719,801	\$ 122,936		\$ 122,936	\$	\$ 2,823,505		34

\*\*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	\$ 652,939	\$ 57,266	\$ 57,266	\$		\$ 470,478	71
72	Current Year Purchases	51,547	13,066	13,066			13,067	72
73	Fully Depreciated Assets	936,467	129	129			846,323	73
74								74
75	TOTALS	\$ 1,640,953	\$ 70,461	\$ 70,461	\$		\$ 1,329,868	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/Improvements	Ford, Van, 1985	1985	\$ 26,794	\$	\$	\$	5	\$ 26,794	76
77	Van/Improvements	Ford, 1992 & Lift	1995/1996	15,155				5	15,155	77
78	Van/Improvements	Ford, Van, 1985	1997	3,240				5	3,240	78
79	Resident Transport	Buick, LeSabre, 1995	2002	5,495	785	785		7	2,748	79
80	TOTALS			\$ 50,684	\$ 785	\$ 785	\$		\$ 47,937	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)	\$	5,433,649	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	194,182	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$	194,182	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$		84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$	4,201,310	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: \_\_\_\_\_

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

If NO, see instructions.  YES  NO

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

10. Effective dates of current rental agreement:  
Beginning \_\_\_\_\_  
Ending \_\_\_\_\_

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

	Fiscal Year Ending	Annual Rent
12.	_____/2006	\$ _____
13.	_____/2007	\$ _____
14.	_____/2008	\$ _____

8. List separately any amortization of lease expense included on page 4, line 34.  
This amount was calculated by dividing the total amount to be amortized  
by the length of the lease \_\_\_\_\_.

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

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

15. Is Movable equipment rental included in building rental?  YES  NO

16. Rental Amount for movable equipment: \$ \_\_\_\_\_ Description: \_\_\_\_\_  
(Attach a schedule detailing the breakdown of movable equipment)

\* 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.

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

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

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

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

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

- (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.

**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)	
<b>TOTAL TRAINED</b>	

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

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8	
			Units of Service	Cost	Outside Practitioner (other than consultant)		Total Cost (Col. 3 + 5 + 6)							
					Units	Cost								
1	Licensed Occupational Therapist		hrs	\$										
2	Licensed Speech and Language Development Therapist	10a	hrs			11	390					11	390	2
3	Licensed Recreational Therapist		hrs											3
4	Licensed Physical Therapist	10a	hrs			182	6,744					182	6,744	4
5	Physician Care		visits											5
6	Dental Care		visits											6
7	Work Related Program		hrs											7
8	Habilitation		hrs											8
9	Pharmacy		# of prescripts											9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs											10
11	Academic Education		hrs											11
12	Exceptional Care Program													12
13	Other (specify):													13
14	<b>TOTAL</b>			\$		193	\$ 7,134	\$				193	\$ 7,134	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.

## STATE OF ILLINOIS

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Facility Name &amp; ID Number St Paul's Home

# 0013920

Report Period Beginning: 01/01/05

Ending:

12/31/05

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/05

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 76,659	\$ 86,604	1
2	Cash-Patient Deposits	7,096	7,096	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	326,908	326,908	3
4	Supply Inventory (priced at )	26,146	26,146	4
5	Short-Term Investments		1,244,842	5
6	Prepaid Insurance	108,616	108,616	6
7	Other Prepaid Expenses	18,689	23,145	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <b>Interest Receivable</b>		45,022	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 564,114	\$ 1,868,379	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable		1,260,000	11
12	Long-Term Investments	6,303		12
13	Land	245,755	245,755	13
14	Buildings, at Historical Cost	8,949,475	8,949,475	14
15	Leasehold Improvements, at Historical Cost	99,052	99,052	15
16	Equipment, at Historical Cost	1,886,183	1,902,898	16
17	Accumulated Depreciation (book methods)	(6,611,366)	(6,615,931)	17
18	Deferred Charges	507	507	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):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 4,575,909	\$ 5,841,756	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 5,140,023	\$ 7,710,135	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 139,179	\$ 139,179	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	7,096	7,096	28
29	Short-Term Notes Payable	3,124,046	3,124,046	29
30	Accrued Salaries Payable	52,651	52,651	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	57,487	57,487	33
34	Deferred Compensation	5,460	5,460	34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<b>Line of Credit - Medicaid Rec.</b>	209,000	209,000	36
37	<b>Advances for NonCare Operations</b>	1,260,000	1,260,000	37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 4,854,919	\$ 4,854,919	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	19,500	19,500	42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 19,500	\$ 19,500	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 4,874,419	\$ 4,874,419	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 265,604	\$ 2,835,716	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 5,140,023	\$ 7,710,135	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,980,579	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,980,579	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	(326,716)	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) Apartment Community Operations	46,636	15
16	Other (describe) Foundation Operations	135,217	16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (144,863)	17
<b>B. Transfers (Itemize):</b>			
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)	\$ 2,835,716	24 *

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

STATE OF ILLINOIS

Facility Name & ID Number St Paul's Home

# 0013920

Report Period Beginning: 01/01/05

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12/31/05

**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 3,900,410	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 3,900,410	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	3,000	24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 3,000	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See attachment pg 27</u>	66,066	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 66,066	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 3,969,476	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,144,631	31
32	Health Care	1,630,834	32
33	General Administration	1,185,365	33
<b>B. Capital Expense</b>			
34	Ownership	270,816	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	2,678	35
36	Provider Participation Fee	61,868	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 4,296,192	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(326,716)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (326,716)	43

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

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

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

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

Facility Name &amp; ID Number St Paul's Home

# 0013920

Report Period Beginning: 01/01/05

Ending: 12/31/05

12/31/05

## 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	2,080	2,240	\$ 56,896	\$ 25.40	1
2	Assistant Director of Nursing	2,080	2,240	46,178	20.62	2
3	Registered Nurses	8,431	9,397	144,691	15.40	3
4	Licensed Practical Nurses	25,409	28,637	386,344	13.49	4
5	CNAs & Orderlies	74,995	85,622	819,002	9.57	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,510	2,190	20,820	9.51	8
9	Activity Director	1,040	1,120	13,200	11.79	9
10	Activity Assistants	2,902	3,190	37,712	11.82	10
11	Social Service Workers	3,783	4,172	48,514	11.63	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,240	42,641	19.04	13
14	Head Cook	2,080	2,240	19,612	8.76	14
15	Cook Helpers/Assistants	10,278	11,426	95,024	8.32	15
16	Dishwashers	15,234	16,411	109,687	6.68	16
17	Maintenance Workers	6,283	7,042	75,831	10.77	17
18	Housekeepers	19,238	21,089	177,052	8.40	18
19	Laundry	9,649	10,410	80,382	7.72	19
20	Administrator	2,080	2,240	69,746	31.14	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,080	2,240	35,821	15.99	23
24	Clerical	12,528	13,492	103,584	7.68	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					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	203,760	227,638	\$ 2,382,737 *	\$ 10.47	34

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

\*\* See instructions.

## B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	139	\$ 6,273	1/3	35
36	Medical Director		9,161	9/3	36
37	Medical Records Consultant		600	10/3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	96	3,250	10/3	39
40	Physical Therapy Consultant	182	6,744	10a/3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	11	390	10a/3	43
44	Activity Consultant	16	791	11/3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	444	\$ 27,209		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	212	3,964	10/3	52
53	TOTAL (lines 50 - 52)	212	\$ 3,964		53

Facility Name & ID Number St Paul's Home

# 0013920

Report Period Beginning: 01/01/05

Ending: 12/31/05

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	
Kimberly Cornell	Executive Director	0	\$ 21,432	Workers' Compensation Insurance	\$ 77,441	IDPH License Fee	\$ 968	
Betty Gibbons	Interim Director	0	48,314	Unemployment Compensation Insurance	27,137	Advertising: Employee Recruitment	5,559	
				FICA Taxes	176,836	Health Care Worker Background Check (Indicate # of checks performed <u>51</u> )	816	
				Employee Health Insurance	245,107	Resident Background Checks (32)	512	
				Employee Meals		Promotion and Advertising	9,868	
				Illinois Municipal Retirement Fund (IMRF)*		Life Services Network	5,845	
				Employee Relations Expense	3,189	Newspapers & Subscriptions	1,001	
				Employee Life Insurance	7,022			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 69,746			Less: Public Relations Expense ( )		
B. Administrative - Other						Non-allowable advertising	7,461	
Description			Amount			Yellow page advertising	2,407	
St. Andrew's			\$ 182,979					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 182,979	TOTAL (agree to Schedule V, line 22, col.8)	\$ 536,732	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 14,701	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
ADP	Payroll Processing		\$ 10,352				Out-of-State Travel	\$
Rice, Sullivan	Audit Fees		8,723					
Greensfelder	Legal Fees		5,927				In-State Travel	430
Blackwell Sanders	Legal Fees		10,000					
							Seminar Expense	1,090
							Entertainment Expense ( )	
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 35,002	TOTAL		\$	TOTAL	\$ 1,520

\* Attach copy of IMRF notifications

\*\*See instructions.

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

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	Interior Painting	04/2000	\$ 134	3	\$ 50	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0	\$	\$
2	Interior Painting	09/2000	172	3	60	0	0	0	0			
3	Interior Painting	09/2000	135	3	48	32	0	0	0			
4	Interior Painting	11/2002	81	3	4	23	24	24	5	0		
5	Interior Painting	06/2003	605	3	0	24	202	202	83	0		
6	Interior Painting	04/2003	85	3	0	118	28	28	8	0		
7	Interior Painting	02/2003	257	3	0	21	86	86	6	0		
8	Interior Painting	04/2004	87	3	0	79	22	29	29	7		
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS		\$ 1,556		\$ 162	\$ 297	\$ 362	\$ 369	\$ 131	\$ 7	\$	\$



St. Paul's Home  
IDPH Facility ID #0013920  
01/01/05-12/31/05

Attachment to Schedule X, Building and General Information

Schedule X, A, Number of Stories

Nursing Facility is comprised of 6 buildings:

2 Buildings are 2 stories

4 Buildings are 1 story, 3 of which have basements

Attachment to Schedule XI, A, Land, Line 1, Column 4

General Ledger balance of \$17,386 reduced to \$16,901 by 1982 audit

Attachment to Schedule XIII Expenses Relating to Nurse Aide Training Programs Page 15

St. Paul's Home only hires CNA's that have already completed a certified nurse aides training program and are currently listed in the Illinois CNA registry.

Supplement to Schedule V, Cost Center Expenses

Line 27, Column 4

Sundry expenses and incidental supplies	5,347
"Compliance" ad cost	28
Finance Charges	601
IDPA - Civil Monetary penalty	5,000
	<u>10,976</u>

St. Paul's Home  
IDPH Facility ID # 0013920  
01/01/05 - 12/31/05

Supplement to Schedule V, Line 24, Column 3, Travel and Seminar

Attended by: All Employees  
Date: 11/3/2005  
Location: Belleville, IL  
Title: Abuse  
Sponsor: Outcome Services of Illinois  
Cost: \$ 150.00  
Justification: To learn about abuse prevention.

Attended by: Pam Woodward, DON  
Mary Neuman, ADON  
Date: 10/12/2005  
Location: Freeburg, IL  
Title: Fall Conference - Medicare D  
Sponsor: LTC DON of Metro East  
Cost: \$ 100.00  
Justification: To learn about Medicare D.

Attended by: Betty Gibbons, Interim Direcotr  
Date: 8/26/2006  
Location: Belleville, IL  
Title: Medicare D  
Sponsor: Life Services Network  
Cost: \$ 375.00  
Justification: To gain valuable knowledge regarding Medicare D.

Miscellaneous Travel and Seminar expenses	\$ 895.00
Total Seminar and Travel Expenses	<u>\$ 625.00</u>
	<u>\$ 1,520.00</u>

St. Paul's Home  
IDPH Facility ID #0013920  
01/01/05-12/31/05

Attachment to Schedule VII, Related Parties

St. Paul's Home Board of Directors

Mr. William Lindauer, Chairperson  
Mr. Richard Binder, Vice Chairperson  
Mr. Belmont Valentine, Treasurer  
Mr. Thomas Mentzer, Secretary  
Mr. Bob DeCamp, Director  
Mr. Dale Kurrus, Director  
Mrs. Kristine Mueller, Director  
Mr. Michael Pierce, Director  
Mr. Cary Smith, Director  
Rev. Andrew Kramer, Director

All Officers and Directors listed above receive no compensation and serve on a voluntary basis and donate whatever time is necessary on a part-time basis.

St. Paul's Home  
IDPH Facility ID #0013920  
01/01/05-12/31/05

Attachment to Schedule XV, Balance Sheet, Line 34, Column 1

Account Title should be Deferred Revenue, not Deferred Compensation

Attachment to XV, Balance Sheet, Line 42, Column 2

Account Title should be Deferred Revenue, not Deferred Compensation

Attachment to Schedule XVII, Other Income, Line 28 Column 1

Administrative Support Income from Foundation	48,000
Other Income	<u>18,066</u>
	<u><u>66,066</u></u>

St. Paul's Home  
IDPH Facility ID #0013920  
01/01/05-12/31/05

Summary of Legal Services (copies of invoices attached)

Statement for legal services rendered through April 30, 2005

Legal services regarding corporate, resident and employee matters. 2,926.69

Statement for legal services rendered through May 31, 2005

Legal services regarding corporate, resident and employee matters. 982.30

Statement for legal services rendered through June 30, 2005

Legal services regarding corporate, resident and employee matters. 722.14

Statement for legal services rendered through July 31, 2005

Legal services regarding corporate, resident and employee matters. 1,115.40

Statement for legal services rendered through October 31, 2005

Legal services regarding corporate, resident and employee matters. 180.40

Statement for legal services rendered through

Legal services regarding corporate, resident and employee matters. 10,000.00

TOTAL LEGAL SERVICES:

15,926.93