



Facility Name & ID Number St Paul's Home

# 0013920 Report Period Beginning: 01/01/06 Ending: 12/31/06

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	113	Intermediate (ICF)	113	41,245	3
4		Intermediate/DD			4
5	62	Sheltered Care (SC)	62	22,630	5
6		ICF/DD 16 or Less			6
7	175	TOTALS	175	63,875	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment			
		Medicaid Recipient	Private Pay	Other	
8	SNF				8
9	SNF/PED				9
10	ICF	25,495	11,447		36,942
11	ICF/DD				11
12	SC	5,337	1,188		6,525
13	DD 16 OR LESS				13
14	TOTALS	30,832	12,635		43,467

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 68.05%

D. How many bed-hold days during this year were paid by the Department? 0 (Do not include bed-hold days in Section B.)

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

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/06 Fiscal Year: 12/31/06

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

Facility Name & ID Number St Paul's Home # 0013920 Report Period Beginning: 01/01/06 Ending: 12/31/06

**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
	<b>A. General Services</b>										
1	Dietary	282,334	36,661	6,971	325,966		325,966		325,966		1
2	Food Purchase		199,028		199,028		199,028		199,028		2
3	Housekeeping	178,510	24,561		203,071		203,071		203,071		3
4	Laundry	86,167	7,970		94,137		94,137		94,137		4
5	Heat and Other Utilities			236,503	236,503		236,503		236,503		5
6	Maintenance	85,524	60,117	16,291	161,932		161,932		161,932		6
7	Other (specify):* <b>Security</b>	11,202			11,202		11,202		11,202		7
8	<b>TOTAL General Services</b>	643,737	328,337	259,765	1,231,839		1,231,839		1,231,839		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	1,513,766	37,189	2,435	1,553,390		1,553,390		1,553,390		10
10a	Therapy			7,325	7,325		7,325		7,325		10a
11	Activities	61,093	5,049	228	66,370		66,370		66,370		11
12	Social Services	42,054			42,054		42,054		42,054		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,616,913	42,238	15,988	1,675,139		1,675,139		1,675,139		16
	<b>C. General Administration</b>										
17	Administrative	60,962		202,337	263,299		263,299		263,299		17
18	Directors Fees										18
19	Professional Services			27,780	27,780		27,780		27,780		19
20	Dues, Fees, Subscriptions & Promotions			31,282	31,282		31,282	(14,033)	17,249		20
21	Clerical & General Office Expenses	98,378	7,353	31,090	136,821		136,821		136,821		21
22	Employee Benefits & Payroll Taxes			538,714	538,714		538,714	(1,272)	537,442		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,811	1,811		1,811		1,811		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			141,272	141,272		141,272		141,272		26
27	Other (specify):* <b>See Non-allowable expenses, pg 5 &amp; 5A</b>			34,298	34,298		34,298	(34,298)			27
28	<b>TOTAL General Administration</b>	159,340	7,353	1,008,584	1,175,277		1,175,277	(49,603)	1,125,674		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,419,990	377,928	1,284,337	4,082,255		4,082,255	(49,603)	4,032,652		29

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

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

Facility Name &amp; ID Number

St Paul's Home

#0013920

Report Period Beginning:

01/01/06

Ending:

12/31/06

## 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			198,292	198,292		198,292	(6,464)	191,828			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			100,279	100,279		100,279		100,279			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>			298,571	298,571		298,571	(6,464)	292,107			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation			1,987	1,987		1,987		1,987			38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			62,011	62,011		62,011		62,011			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			63,998	63,998		63,998		63,998			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,419,990	377,928	1,646,906	4,444,824		4,444,824	(56,067)	4,388,757			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	
	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	(1,272)	22		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	(3,090)	27		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	(24,014)	27		24
25	Fund Raising, Advertising and Promotional	(11,504)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(2,501)	20		28
29	Other-Attach Schedule <u>see Page 5A</u>	(13,686)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (56,067)		\$	30

BHF USE ONLY					
48		49		50	
				51	
					52

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

		1	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)			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>	\$ (56,067)		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.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			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: 01/01/06

Ending: 12/31/06

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Catawba Property Expenses	\$ (4,717)	27	1
2	Krummrich Property Expenses	(2,430)	27	2
3	Miscellaneous Sundry Items	(47)	27	3
4	Compliance Ad Cost	(28)	20	4
5	Catawba Depreciation	(3,510)	30	5
6	Krummrich Depreciation	(2,954)	30	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>	(13,686)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number St Paul's Home# 0013920

Report Period Beginning:

01/01/06

Ending:

12/31/06

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

	Operating Expenses	PAGES	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	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>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>8</b>
	<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>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<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	(14,033)	0	0	0	0	0	0	0	0	0	0	(14,033)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	(1,272)	0	0	0	0	0	0	0	0	0	0	(1,272)	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):*	(34,298)	0	0	0	0	0	0	0	0	0	0	(34,298)	27
28	<b>TOTAL General Administration</b>	<b>(49,603)</b>	<b>0</b>	<b>(49,603)</b>	<b>28</b>									
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(49,603)</b>	<b>0</b>	<b>(49,603)</b>	<b>29</b>									

STATE OF ILLINOIS

Summary B

Facility Name & ID Number St Paul's Home

# 0013920

Report Period Beginning:

01/01/06

Ending:

12/31/06

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

	Capital Expense	PAGES	PAGE	SUMMARY TOTALS										
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(6,464)	0	0	0	0	0	0	0	0	0	0	(6,464)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(6,464)</b>	<b>0</b>	<b>(6,464)</b>	<b>37</b>									
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(56,067)</b>	<b>0</b>	<b>(56,067)</b>	<b>45</b>									

**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
See attached schedule, page 24.				St. Paul's Home Foundation	Belleville	Not for Profit
				St. Paul's Home Retirement Community	Belleville	Not for Profit

**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	Total		\$			\$	\$ *	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: 01/01/06 Ending: 12/31/06

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2	None										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: 01/01/06 Ending: 12/31/06

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

Facility Name & ID Number

St Paul's Home

# 0013920

Report Period Beginning:

01/01/06

Ending:

12/31/06

**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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	Southwest Bank		X	Real Estate Mortgage	\$3,126.00	12/22/06	\$ 532,817	\$ 532,817	12/22/11	0.0704	\$ 1,028	1								
2	Regions Bank		X	Real Estate Mortgage	\$6,151.00	12/13/01	677,526		12/13/06	0.0706	35,612	2								
3	Regions Bank		X	Real Estate Mortgage	\$540.00	12/13/01	59,498		12/13/06	0.0706	4,111	3								
4												4								
5												5								
<b>Working Capital</b>																				
6	Southwest Bank		X	Provide Operating Funds		12/22/06	300,000		12/22/11	0.0785		6								
7	Regions Bank		X	Provide Operating Funds		07/05/05	210,000		07/05/06	0.0750	18,360	7								
8	St. Paul's Foundation	X		Provide Operating Funds		01/01/05	917,500	1,468,500	01/01/08	0.0300	41,168	8								
9	TOTAL Facility Related				\$9,817.00		\$ 2,697,341	\$ 2,001,317			\$ 100,279	9								
<b>B. Non-Facility Related*</b>																				
10	Southwest Bank		X	Real Estate Mortgage	\$15,584.00	12/22/06	2,656,727	2,656,727	12/22/11	0.0704	3,924	10								
11	Regions Bank		X	Real Estate Mortgage	\$27,507.00	12/01/01	3,027,307		12/05/06	0.0706	176,733	11								
12	See attached page 24 for reconciliation of interest expense to schedule V.																			
13												13								
14	TOTAL Non-Facility Related				\$43,091.00		\$ 5,684,034	\$ 2,656,727			\$ 180,657	14								
15	TOTALS (line 9+line14)						\$ 8,381,375	\$ 4,658,044			\$ 280,936	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.)



**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 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 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2006 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 Bureau of Health Finance at (217) 782-1630.

**2005 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 Cost**

Enter the tax index number and real estate tax assessed for 2005 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 2005.

(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. EXEMPT	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ _____	\$ _____

**B. Real Estate Tax Cost Allocations**

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

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

**C. Tax Bills**

Attach a copy of the original 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

**PLEASE NOTE:** Payment information from the Internet or otherwise is not considered acceptable tax bill documentation. Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number St Paul's Home

# 0013920 Report Period Beginning:

01/01/06 Ending:

12/31/06

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 56,032 B. General Construction Type: Exterior Brick Frame \_\_\_\_\_ Number of Stories See attached pg 24

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).  
St. Paul's Home Retirement Community; independent living apartments; 62,500 sq. ft.; 53 apartments

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>Resident Use</u>	<u>178,000</u>	<u>1926</u>	<u>\$ 16,901</u>	<u>1</u>
2	<u>See attached page 26</u>			<u>5,795</u>	<u>2</u>
3	<b>TOTALS</b>	<b>178,000</b>		<b>\$ 22,696</b>	<b>3</b>

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

# 0013920

Report Period Beginning:

01/01/06

Ending:

12/31/06

**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 BHF 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	2,964	50	2,964		145,290	5
6	38	1962	1962	266,977	5,895	50	5,895		245,353	6
7	75	1971	1971	654,498	15,967	40	15,967		583,547	7
8		1981	1981	718,105	16,833	40	16,833		468,409	8
<b>Improvement Type**</b>										
9		1961	1961	14,618		25			14,618	9
10		1963	1963	594		25			594	10
11		1971	1971	40,791		25			40,791	11
12		1973	1973	1,471		25			1,471	12
13		1974	1974	1,162		20			1,162	13
14		1975	1975	7,723		25			7,723	14
15		1976	1976	75,275	2,014	35	2,014		66,209	15
16		1977	1977	13,703		10			13,703	16
17		1978	1978	24,680		25			24,680	17
18		1979	1979	454,801	15,160	30	15,160		416,901	18
19		1980	1980	5,908		20			5,908	19
20		1982	1982	44,406		10			44,406	20
21		1983	1983	6,581		10			6,581	21
22		1984	1984	8,251		10			8,251	22
23		1985	1985	2,786		10			2,783	23
24		1986	1986	17,208	3,366	20	3,366		16,697	24
25		1987	1987	169,475	3,972	20	3,972		147,128	25
26		1989	1989	38,131		15			38,131	26
27		1991	1991	109,995	4,664	20	4,664		87,619	27
28		1992	1992	54,380	862	10	862		45,340	28
29		1993	1993	6,300	252	25	252		3,528	29
30		1994	1994	45,495	2,862	15	2,862		39,190	30
31		1995	1995	21,589		10			21,589	31
32	Repaved parking lot / sidewalk improvements	1996	1996	19,616	1,112	15	1,112		17,245	32
33	Dishroom renovation and door installation	1996	1996	38,379	1,919	20	1,919		21,918	33
34	Remodeled administrative office area	1996	1996	9,218	615	15	615		6,454	34
35	Installation of fences	1996	1996	4,099		10			4,099	35
36	Supplemental lighting for parking lot	1997	1997	1,225	82	10	82		818	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:

01/01/06

Ending:

12/31/06

## 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	\$	\$ 10,638	37
38	Building for emergency generator	1997	33,000	1,000	33	1,000		10,000	38
39	Structural improvements to Kohl wing	1997	21,878	1,806	20	1,806		12,945	39
40	Installation of fences	1997	1,823	182	10	182		1,731	40
41	Telephone alcove and construction of wall divider	1997	3,690	246	15	246		2,460	41
42	Internal corridor doors	1997	4,118	340	10	340		4,048	42
43	Remodeling / redecorating of resident rooms / areas	1997	29,198	2,411	10	2,411		28,084	43
44	Aluminum ramps / brackets for porch area	1998	1,121		5			1,121	44
45	Tuckpointing / caulking of retaining wall	1998	2,500	156	8	156		2,499	45
46	Soffitt / fascia installation	1998	13,194	660	20	660		5,608	46
47	Wallcovering (employee dining room and main corridor)	1998	2,765	277	10	277		2,490	47
48	Roof replacement (kohl wing)	1998	31,078	2,180	10	2,180		18,524	48
49	Remodeling of shower room (kohl wing)	1998	3,836	384	10	384		3,261	49
50	Roof repairs (ludwig wing)	1998	1,620	162	10	162		1,377	50
51	Shelter nurses' station renovation	1999	7,194	719	10	719		5,754	51
52	Structural repairs to Kohl wing	1999	1,988	199	10	199		1,591	52
53	Shower stall and flooring replacements (Kohl wing)	1999	4,418	442	10	442		3,535	53
54	Panic hardware for Ludwig front door	1999	527		5			527	54
55	Bartel wing lighting	1999	5,034	503	10	503		3,775	55
56	Valves for domestic water line	1999	1,927	193	10	193		1,501	56
57	Water supply lines for cooling tower	1999	592	59	10	59		333	57
58	Chapel roof repairs	1999	3,025	302	10	302		2,268	58
59	Bartel wing soiled linen room remodeling	2000	7,860	524	15	524		3,668	59
60	Water covers for entry main corridor	2000	1,209	121	10	121		786	60
61	Replacement of Bartel wing sewer line	2000	16,237	812	20	812		5,683	61
62	Kitchen lighting project	2001	13,493	675	20	675		4,049	62
63	Exit seeker system	2001	10,767	1,077	10	1,077		6,461	63
64	Ludwig wing sewer project	2001	12,719	636	20	636		3,498	64
65	Master antennae system (Bartel wing)	2001	2,149	215	10	215		1,182	65
66	Window project (Bartel wing)	2001	22,442	898	25	898		4,938	66
67	Laundry dedicated electrical circuit	2001	840	84	10	84		462	67
68	Fire and smoke doors in Bartel long hall	2002	3,292	219	15	219		1,097	68
69	Chapel roof repairs	2002	25,974	2,597	10	2,597		12,986	69
70	TOTAL (lines 4 thru 69)		\$ 3,494,829	\$ 99,469		\$ 99,469	\$	\$ 2,883,582	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:

01/01/06

Ending:

12/31/06

**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	<b>Totals from Page 12A, Carried Forward</b>		\$ 3,494,829	\$ 99,469		\$ 99,469	\$	\$ 2,883,582	1
2									2
3	Chapel - electric work	2002	3,450	345	10	345		1,725	3
4	Kitchen - A/C	2002	1,612	161	10	161		806	4
5	Kitchen - walk-in refrigerator unit	2002	2,740	274	10	274		1,370	5
6	Kitchen - water storage tank replacement	2002	5,145	257	20	257		1,286	6
7	Front entry and walk	2002	34,288	2,286	10	2,286		10,858	7
8	Chapel - A/C unit	2002	8,410	841	10	841		4,205	8
9	Kitchen - walk-in freezer replacement	2002	4,750	475	10	475		2,137	9
10	Kitchen range hood electrical shut down project	2003	2,269	151	15	151		605	10
11	Lamp posts	2003	955	64	15	64		242	11
12	Front walk project	2003	8,583	858	10	858		3,433	12
13	West drive project	2003	2,115	212	10	212		847	13
14	New floor tile and subfloor room 102 Kohl wing	2003	2,135	213	10	213		746	14
15	Install new metal door for dishroom	2003	1,708	171	10	171		598	15
16	Fresh air intake for laundry room	2003	5,893	589	10	589		2,062	16
17	Repair exterior wall of employee dining room	2003	8,303	830	10	830		2,906	17
18	Hot water plumbing project	2004	33,937	1,697	20	1,697		5,091	18
19	Install shower thresholds (Bartel)	2004	1,550	155	10	155		465	19
20	Repair / Replaster North & West walls in employee dining room	2004	3,291	329	10	329		987	20
21	Wall guards for 12 resident rooms and handrail main hall	2004	1,313	131	10	131		394	21
22	Paint walls, ceilings, around windows in resident rooms	2004	13,179	1,318	10	1,318		3,954	22
23	Replace bad section of cast iron waste line	2004	862	86	10	86		258	23
24	Install acoustical ceiling in room 209	2004	855	85	10	85		256	24
25	Kohl wing HVAC air handler heating system	2004	1,937	194	10	194		485	25
26	Kohl and Ludwig front walk project	2004	1,111	111	10	111		278	26
27	Sprinkler Head installed in office stair well and workshop	2005	1,446	145	10	145		290	27
28	20 gallon water storage tank	2005	10,415	1,042	10	1,042		1,997	28
29	State architect survey consultation	2005	1,976	198	10	198		346	29
30	Fire dampers and smoke dampers	2005	489	49	10	49		86	30
31	Ludwig roof	2005	49,368	4,937	10	4,937		8,228	31
32	Ludwig roof	2005	5,485	549	10	549		915	32
33	Master antenna system on new roof	2005	1,075	108	10	108		180	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 3,715,474	\$ 118,330		\$ 118,330	\$	\$ 2,941,618	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	<b>Totals from Page 12B, Carried Forward</b>		\$ 3,715,474	\$ 118,330		\$ 118,330	\$	\$ 2,941,618	1
2	State architect survey consultation	2005	875	88	10	88		132	2
3	State architect survey consultation	2005	2,452	245	10	245		368	3
4	State architect survey consultation	2005	1,000	100	10	100		150	4
5	Life service code updates	2006	2,751	244	10	244		244	5
6	Fire safety, smoke detectors, fire suppression system	2006	25,370	1,002	10	1,002		1,002	6
7	Generator tubing line	2006	5,787	263	10	263		263	7
8	Boiler room door and system	2006	15,061	497	10	497		498	8
9	Furnish and install ductwork from grill to handler	2006	3,728	298	10	298		298	9
10	Ceiling repair & fire proofing in Roediger and Bartel	2006	11,498	559	10	559		559	10
11	Replace chiller & refrigerant; replace compressors for HVAC	2006	8,452	598	10	598		598	11
12	Front walk and railings - Life Safety Code	2006	25,913	1,296	10	1,296		1,296	12
13	Door Replacements - Life Safety Code	2006	4,613	192	10	192		192	13
14	Life Safety Code for Concrete ramp, pad and railings	2006	4,598	38	10	38		38	14
15	Architect for changes to ICF Wing	2006	2,500	143	10	143		143	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	<b>TOTAL (lines 1 thru 33)</b>		\$ 3,830,072	\$ 123,893		\$ 123,893	\$	\$ 2,947,399	34

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

Facility Name & ID Number St Paul's Home

# 0013920

Report Period Beginning:

01/01/06

Ending:

12/31/06

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	\$ 645,327	\$ 58,235	\$ 58,235	\$		\$ 409,449	71
72	Current Year Purchases	37,204	4,390	4,390			4,390	72
73	Fully Depreciated Assets	995,625	4,525	4,525			995,625	73
74								74
75	TOTALS	\$ 1,678,156	\$ 67,150	\$ 67,150	\$		\$ 1,409,464	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 and wheelchair lift	Econoline, Ford, 1992	1993/1995	\$ 12,110	\$	\$	\$	7	\$ 12,110	76
77	Van improvements	Econoline, Ford, 1992	1996	3,595				5	3,595	77
78	Van improvements	Econoline, Ford, 1992	1997	3,240				5	3,240	78
79	Automobile	LeSabre, Buick, 1995	2002	5,495	785	785		7	3,533	79
80	TOTALS			\$ 24,440	\$ 785	\$ 785	\$		\$ 22,478	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)	\$ 5,555,364	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 191,828	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 191,828	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)	\$ 4,379,341	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	Catawba building, 1991	\$ 99,817	\$ 3,510	\$ 65,596	86
87	Krummrich building, 1988	51,626	2,954	45,651	87
88					88
89					89
90					90
91	TOTALS	\$ 151,443	\$ 6,464	\$ 111,247	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

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

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

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

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

15. Is Movable equipment rental included in building rental? \_\_\_\_\_

YES  NO

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

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

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$ _____	\$ _____	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$ _____	\$ _____	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. \_\_\_\_\_ /2007 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2008 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2009 \$ \_\_\_\_\_

\* 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 CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)**

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <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 CNA _____</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 CNA _____</p>
--	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**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>	

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of 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>			\$		\$	\$		\$	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.

Facility Name & ID Number St Paul's Home

# 0013920

Report Period Beginning: 01/01/06

Ending:

12/31/06

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/06

(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	\$ 203,121	\$ 243,023	1
2	Cash-Patient Deposits	6,297	6,297	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 24,014 )	565,133	571,827	3
4	Supply Inventory (priced at cost )	27,837	27,837	4
5	Short-Term Investments	11,893	903,305	5
6	Prepaid Insurance	48,295	76,659	6
7	Other Prepaid Expenses	33,844	38,584	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 896,420	\$ 1,867,532	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	22,696	245,755	13
14	Buildings, at Historical Cost	3,830,072	9,151,432	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,678,156	1,944,953	16
17	Accumulated Depreciation (book methods)	(4,379,341)	(6,930,361)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spec Vehicles)	24,440	72,807	22
23	Other(specify): Loan issuance costs	1,473	8,822	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,177,496	\$ 4,493,408	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 2,073,916	\$ 6,360,940	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 219,522	\$ 249,484	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	6,297	6,297	28
29	Short-Term Notes Payable	1,468,500		29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	82,760	4,922	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	Accrued Expenses	78,067	80,988	36
37	Deferred Revenue	2,373	14,880	37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,857,519	\$ 356,571	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable	532,817	3,189,544	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	Deferred Revenue		18,140	43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 532,817	\$ 3,207,684	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 2,390,336	\$ 3,564,255	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (316,420)	\$ 2,796,685	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 2,073,916	\$ 6,360,940	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>2,835,716</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Previously reported consolidated total equity</b>	<b>(2,848,253)</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(12,537)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(303,883)</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(303,883)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>(316,420)</b>	<b>24</b> *

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

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

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

1

Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 4,055,833	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 4,055,833	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	530	24
25	Interest and Other Investment Income***	5,771	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 6,301	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See attached page 25</u>	78,807	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 78,807	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 4,140,941	30

2

Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,231,839	31
32	Health Care	1,675,139	32
33	General Administration	1,175,277	33
<b>B. Capital Expense</b>			
34	Ownership	298,571	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	1,987	35
36	Provider Participation Fee	62,011	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 4,444,824	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(303,883)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (303,883)	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 & ID Number St Paul's Home

# 0013920

Report Period Beginning:

01/01/06

Ending:

12/31/06

**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	1,920	2,080	\$ 48,926	\$ 23.52	1
2	Assistant Director of Nursing	1,912	2,080	47,510	22.84	2
3	Registered Nurses	2,931	3,240	58,933	18.19	3
4	Licensed Practical Nurses	25,201	26,175	436,452	16.67	4
5	CNAs & Orderlies	86,928	90,592	870,218	9.61	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	948	1,040	21,565	20.74	9
10	Activity Assistants	4,073	4,294	39,528	9.21	10
11	Social Service Workers	3,017	3,109	42,054	13.53	11
12	Dietician					12
13	Food Service Supervisor	1,889	2,080	43,872	21.09	13
14	Head Cook	3,630	3,798	40,005	10.53	14
15	Cook Helpers/Assistants	25,310	26,203	198,457	7.57	15
16	Dishwashers					16
17	Maintenance Workers	6,140	6,269	85,524	13.64	17
18	Housekeepers	19,479	20,534	178,510	8.69	18
19	Laundry	10,145	10,905	86,167	7.90	19
20	Administrator	2,000	2,080	60,962	29.31	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,104	12,379	98,378	7.95	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	4,500	4,620	51,727	11.20	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Security</u>	1,487	1,518	11,202	7.38	33
34	TOTAL (lines 1 - 33)	213,614	222,996	\$ 2,419,990 *	\$ 10.85	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	\$ 6,766	1-3	35
36	Medical Director	6,000	9-3	36
37	Medical Records Consultant	685	10-3	37
38	Nurse Consultant			38
39	Pharmacist Consultant	1,750	10-3	39
40	Physical Therapy Consultant	7,825	10a-3	40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant	476	11-3	44
45	Social Service Consultant			45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 23,502		49

**C. CONTRACT NURSES**

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	\$		50
51	Licensed Practical Nurses			51
52	Certified Nurse Assistants/Aides			52
53	TOTAL (lines 50 - 52)	\$		53

Facility Name & ID Number St Paul's Home

# 0013920

Report Period Beginning: 01/01/06

Ending: 12/31/06

**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	
Kim Cornell	Executive Director	0	\$ 60,962	Workers' Compensation Insurance	\$ 80,651	IDPH License Fee	\$ 1,531	
				Unemployment Compensation Insurance	22,749	Advertising: Employee Recruitment	4,835	
				FICA Taxes	184,442	Health Care Worker Background Check	347	
				Employee Health Insurance	245,102	(Indicate # of checks performed <u>46</u> )		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Marketing Expense	11,542	
				Employee Life Insurance	3,580	Dues and Subscriptions - Life	5,887	
				Employee Events	918	Services Network		
						Promotion	7,140	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 60,962			Less: Public Relations Expense	( )	
(List each licensed administrator separately.)						Non-allowable advertising	(11,532)	
						Yellow page advertising	(2,501)	
<b>B. Administrative - Other</b>								
Description			Amount	TOTAL (agree to Schedule V, line 22, col.8)			\$ 537,442	
St. Andrew's Management Services			\$ 202,337					
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 202,337	E. Schedule of Non-Cash Compensation Paid to Owners or Employees				
(Attach a copy of any management service agreement)				G. Schedule of Travel and Seminar**				
<b>C. Professional Services</b>				Description			Amount	
Vendor/Payee	Type		Amount	Description	Line #	Amount		
ADP	Payroll Processing		\$ 12,811			\$	Out-of-State Travel	\$ 0
Rice, Sullivan & Co., Ltd.	Audit		10,182					
Greensfelder, Hemker & Gale	Legal		433				In-State Travel	1,112
Daniel Maher Law Offices	Legal		3,223					
Blackwell, Sanders, Peper, Martin, L	Legal		137				Seminar Expense	699
The Lowenbaum Partnership	Legal		108					
Paul R. Hales	Legal		660				Entertainment Expense	( )
Belleville News Democrat	Legal		226				(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 1,811
TOTAL (agree to Schedule V, line 19, column 3)			\$ 27,780	TOTAL			\$	
(If total legal fees exceed \$5,000, attach copy of invoices.)								

\* 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	Amount of Expense Amortized Per Year							
																	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	Interior Painting	04/2000	\$ 134	3	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0	\$	\$	\$	\$											
2	Interior Painting	09/2000	172	3	0	0	0	0	0															
3	Interior Painting	09/2000	135	3	32	0	0	0	0															
4	Interior Painting	11/2002	81	3	23	24	24	5	0															
5	Interior Painting	06/2003	605	3	24	202	202	83	0															
6	Interior Painting	04/2003	85	3	118	28	28	8	0															
7	Interior Painting	02/2003	257	3	21	86	86	6	0															
8	Interior Painting	04/2004	87	3	79	22	29	29	7															
9																								
10																								
11																								
12																								
13																								
14																								
15																								
16																								
17																								
18																								
19																								
20	TOTALS		\$ 1,556		\$ 297	\$ 362	\$ 369	\$ 131	\$ 7	\$	\$	\$	\$											

Facility Name & ID Number St Paul's Home# 0013920

Report Period Beginning:

01/01/06

Ending:

12/31/06**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. Life Services Network \$5,887
- (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
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 10,845 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 during this cost report period. \$ 62,011  
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? Yes If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? 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. \$ No Has any meal income been offset against related costs? No Indicate the amount. \$ \_\_\_\_\_
- (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%  
d. Have vehicle usage logs been maintained? No  
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: Rice, Sullivan & Co., Ltd The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? Yes If no, please explain. \_\_\_\_\_
- (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 \$5,000, have legal invoices and a summary of services performed been attached to this cost report? No  
Attach invoices and a summary of services for all architect and appraisal fees

**St. Paul's Home**  
**IDPH Facility ID #0013920**  
**01/01/06 - 12/31/06**

*Attachment to Schedule VII: Related Parties*

St. Paul's Home Board of Directors:

Rich Binder, Chairperson

Tom Mentzer, Vice Chairperson

Dale Kurrus, Treasurer

Mike Pierce, Secretary

Jim Bohanon, Director

Kim Cornell and Joni Suemnicht

Kristine Mueller, Director

Craig Brethauer, Director

Rev. Drew Kramer, Director

Beverly Brightwell, Director

All officers and directors listed above receive no compensation and serve on a voluntary basis donating necessary time on a part-time basis.

*Supplemental Information for Schedule IX: Non-Facility Related Interest Expense*

St. Paul's Home has a real estate mortgage loan for the related apartment community, detailed on lines 10 and 11. This interest expense is not included on Schedule V, as this is non-facility related. Line 9, column 10 is the total interest expense related to the nursing facility, which is reported on Schedule V, line 32, column 8.

*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 of which 3 have basements

*Attachment to Schedule XIII: Expenses Related to CNA Training Programs*

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

**St. Paul's Home**  
**IDPH Facility ID #0013920**  
**01/01/06 - 12/31/06**

Attachment to Schedule XVII: Income Statement

Other Revenue:

Gain on sale of asset	\$ 200
Administrative support from Foundation	48,000
Other Income	<u>30,607</u>
Total	<u><u>\$ 78,807</u></u>

Other revenue has not been used to offset any expenses.

Attachment to Schedule XX: General Information

(12) There is a 50% salary allocation between activity director and social services employee accounts.

Supplement to Schedule V, line 24, column 3 and Attachment to Schedule XIX: Support Schedules

Schedule G, Schedule of Travel and Seminar:

Employee Name	Title/Department	Seminar Dates	Location	Seminar Title	Seminar Sponsor	Cost
Kim Cornell and Joni Suemnicht	Administrator and Director of Nursing	3/6/2006	Wren Lake, IL	Illinois HealthCare Association (IHCA) Regional Conference	IHCA	\$ 380
Terry Donna	Cook with Dietary Department	3/20/2006	Fairview Heights, IL	Recertification Training Course	Safe Food Handlers Corporation	60
Joni Suemnicht	Director of Nursing	3/29/2006	On-line with certificate	OBRA Timing and Scheduling of MDS 2.0	American Association of Nurse Assement Coordinators	35
CNA's from St. Paul's Home	Certified Nursing Assistants	3/31/2006	Training Manuals	Refresher courses for CAN	Delmar Learning	<u>224</u>
Total Seminar Expense						\$ 699
Miscellaneous Travel Expenses						<u>1,112</u>
Total Travel and Seminar Expense						<u><u>\$ 1,811</u></u>

**St. Paul's Home**  
**IDPH Facility ID #0013920**  
**01/01/06 - 12/31/06**

Attachment to Schedule XI: Ownership Costs

Land:	Square Feet:	Year:	
Resident Use	178,000	1926	\$ 16,901
Land Improvements - Resident Use	-	1995	5,310
To correct prior year's cost basis			<u>485</u>
Total			<u><u>\$ 22,696</u></u>