

Facility Name & ID Number St Paul's House & Health Care Ctr

0005165 Report Period Beginning: 07/01/08 Ending: 06/30/09

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	110	Skilled (SNF)	110	40,150	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	68	Sheltered Care (SC)	68	24,820	5
6		ICF/DD 16 or Less			6
7	178	TOTALS	178	64,970	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total	
		3 Medicaid Recipient	4 Private Pay	Other	Total		
8	SNF	6,276	7,007	5,538	18,821		8
9	SNF/PED						9
10	ICF	3,250	1,581		4,831		10
11	ICF/DD						11
12	SC		10,334		10,334		12
13	DD 16 OR LESS						13
14	TOTALS	9,526	18,922	5,538	33,986		14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 52.31%

D. How many bed-hold days during this year were paid by the Department? None (Do not include bed-hold days in Section B.)

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 11/24/1974

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 110 and days of care provided 5,252

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

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

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

Facility Name & ID Number St Paul's House & Health Care Ctr # 0005165 Report Period Beginning: 07/01/08 Ending: 06/30/09

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	320,535	46,269	237,615	604,419		604,419		604,419		1
2	Food Purchase		278,525		278,525	(17,754)	260,771	(18,006)	242,765		2
3	Housekeeping	173,239	34,771		208,010		208,010		208,010		3
4	Laundry	44,951	13,006		57,957		57,957		57,957		4
5	Heat and Other Utilities			283,831	283,831		283,831		283,831		5
6	Maintenance	103,067	41,761	381,942	526,770		526,770	(7,802)	518,968		6
7	Other (specify):*										7
8	TOTAL General Services	641,792	414,332	903,388	1,959,512	(17,754)	1,941,758	(25,808)	1,915,950		8
	B. Health Care and Programs										
9	Medical Director			12,000	12,000		12,000		12,000		9
10	Nursing and Medical Records	1,871,226	4,124	26,975	1,902,325		1,902,325	(20,033)	1,882,292		10
10a	Therapy			14,482	14,482		14,482		14,482		10a
11	Activities	57,978	614	1,611	60,203		60,203		60,203		11
12	Social Services	86,838	1,282	17,440	105,560		105,560		105,560		12
13	CNA Training										13
14	Program Transportation			6,339	6,339		6,339		6,339		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,016,042	6,020	78,847	2,100,909		2,100,909	(20,033)	2,080,876		16
	C. General Administration										
17	Administrative	97,757		73,214	170,971		170,971		170,971		17
18	Directors Fees										18
19	Professional Services			127,851	127,851		127,851	(1,584)	126,267		19
20	Dues, Fees, Subscriptions & Promotions			70,422	70,422		70,422	(34,145)	36,277		20
21	Clerical & General Office Expenses	367,817	42,573	258,418	668,808		668,808	(160,684)	508,124		21
22	Employee Benefits & Payroll Taxes			751,144	751,144	17,754	768,898		768,898		22
23	Inservice Training & Education										23
24	Travel and Seminar			5,951	5,951		5,951	(417)	5,534		24
25	Other Admin. Staff Transportation			8,715	8,715		8,715	(850)	7,865		25
26	Insurance-Prop.Liab.Malpractice			76,334	76,334		76,334		76,334		26
27	Other (specify):*										27
28	TOTAL General Administration	465,574	42,573	1,372,049	1,880,196	17,754	1,897,950	(197,680)	1,700,270		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,123,408	462,925	2,354,284	5,940,617		5,940,617	(243,521)	5,697,096		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			603,157	603,157		603,157	(71,550)	531,607			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			110,483	110,483		110,483	(91,188)	19,295			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			29,452	29,452		29,452		29,452			35
36	Other (specify):*			13,002	13,002		13,002	(13,002)				36
37	TOTAL Ownership			756,094	756,094		756,094	(175,740)	580,354			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		382,944	528,929	911,873		911,873		911,873			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			60,225	60,225		60,225		60,225			42
43	Other (specify):*	274,455	8,858	7,452	290,765		290,765	(290,765)	(0)			43
44	TOTAL Special Cost Centers	274,455	391,802	596,606	1,262,863		1,262,863	(290,765)	972,098			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,397,863	854,727	3,706,984	7,959,574		7,959,574	(710,027)	7,249,547			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(17,850)	02		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	(71,550)	30		9
10	Interest and Other Investment Income	(65,976)	32		10
11	Discounts, Allowances, Rebates & Refunds	(17,457)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(13,771)	21		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(52,726)	21		24
25	Fund Raising, Advertising and Promotional	(28,771)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(5,374)	20		28
29	Other-Attach Schedule	(436,552)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (710,027)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (710,027)		37

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

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

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

BHF USE ONLY							
48		49		50		51	52

SEE ACCOUNTANTS' COMPILATION REPORT

St Paul's House & Health Care Ctr

ID# 0005165

Report Period Beginning: 07/01/08

Ending: 06/30/09

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Miscellaneous Income	\$ (4,529)	21	1
2	Miscellaneous Income - Nursing	(20,033)	10	2
3	LOC Commission	(56,525)	21	3
4	Administrative Non-Allowable	(8,801)	21	4
5	Marketing Travel Expense	(850)	25	5
6	Assisted Living - Salaries	(220,367)	43	6
7	Assisted Living - Supplies	(8,858)	43	7
8	Assisted Living - Other	(3,644)	43	8
9	Intercompany Interest Expense	(25,212)	32	9
10	Other Revenue	(6,743)	21	10
11	Vending Revenue	(156)	02	11
12	ID Badges Revenue	(95)	21	12
13	Copy Revenue	(37)	21	13
14	Amort of Deferred Financing Costs - Interest Expense	(13,002)	36	14
15	Non Allowable Legal	(1,584)	19	15
16	Non Allowable Consulting	(60)	24	16
17	Saint Paul Foundation:	(3,809)	43	17
18	Marketing Salaries	(54,087)	43	18
19	Non Allowable Seminar	(357)	24	19
20	Capitalized R&M	(7,802)	06	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	Total	(436,552)		49

St Paul's House & Health Care Ctr

ID# 0005165

Report Period Beginning: 07/01/08

Ending: 06/30/09

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
50		\$	1
51			2
52			3
53			4
54			5
55			6
56			7
57			8
58			9
59			10
60			11
61			12
62			13
63			14
64			15
65			16
66			17
67			18
68			19
69			20
70			21
71			22
72			23
73			24
74			25
75			26
76			27
77			28
78			29
79			30
80			31
81			32
82			33
83			34
84			35
85			36
86			37
87			38
88			39
89			40
90			41
91			42
92			43
93			44
94			45
95			46
96			47
97			48
98			49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number St Paul's House & Health Care Ctr# 0005165

Report Period Beginning:

07/01/08

Ending:

06/30/09

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													1
2	Food Purchase	(18,006)											(18,006)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities													5
6	Maintenance	(7,802)											(7,802)	6
7	Other (specify):*													7
8	TOTAL General Services	(25,808)											(25,808)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(20,033)											(20,033)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	TOTAL Health Care and Programs	(20,033)											(20,033)	16
	C. General Administration													
17	Administrative													17
18	Directors Fees													18
19	Professional Services	(1,584)											(1,584)	19
20	Fees, Subscriptions & Promotions	(34,145)											(34,145)	20
21	Clerical & General Office Expenses	(160,684)											(160,684)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(417)											(417)	24
25	Other Admin. Staff Transportation	(850)											(850)	25
26	Insurance-Prop.Liab.Malpractice													26
27	Other (specify):*													27
28	TOTAL General Administration	(197,680)											(197,680)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(243,521)											(243,521)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number St Paul's House & Health Care Ctr

0005165

Report Period Beginning:

07/01/08

Ending:

06/30/09

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

	Capital Expense	PAGES	PAGE	SUMMARY									
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS
													(to Sch V, col.7)
30	Depreciation	(71,550)											(71,550) 30
31	Amortization of Pre-Op. & Org.												31
32	Interest	(91,188)											(91,188) 32
33	Real Estate Taxes												33
34	Rent-Facility & Grounds												34
35	Rent-Equipment & Vehicles												35
36	Other (specify):*	(13,002)											(13,002) 36
37	TOTAL Ownership	(175,740)											(175,740) 37
	Ancillary Expense												
	E. Special Cost Centers												
38	Medically Necessary Transportation												38
39	Ancillary Service Centers												39
40	Barber and Beauty Shops												40
41	Coffee and Gift Shops												41
42	Provider Participation Fee												42
43	Other (specify):*	(290,765)											(290,765) 43
44	TOTAL Special Cost Centers	(290,765)											(290,765) 44
	GRAND TOTAL COST												
45	(sum of lines 29, 37 & 44)	(710,027)											(710,027) 45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
N/A		See Attached		See Attached		

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	17	Administrative Expenses	\$ 73,214	Lutheran Life Communities	100.00%	\$ 73,214	\$	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		\$ 73,214			\$ 73,214	\$ *		14

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: 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		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: 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		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: 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		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: 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		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: 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		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: 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		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: 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		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: 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		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: 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		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

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

Facility Name & ID Number St Paul's House & Health Care Ctr # 0005165 Report Period Beginning: 07/01/08 Ending: 06/30/09

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	Roger Paulsberg	Chairman	Administrative	0%	381,154	4.00	10.00%	Alloc. Salary	\$ 38,115	17-3	1
2	Carl Moellenkamp	Vice President	Administrative	0%	218,556	2.00	5.00%	Alloc. Salary	10,928	17-3	2
3	Jim Holbrook	Treasurer	Administrative	0%	217,846	4.00	10.00%	Alloc. Salary	21,785	17-3	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 70,828		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Paul's House & Health Care Ctr # 0005165 Report Period Beginning: 07/01/08 Ending: 06/30/09

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 Lutheran Life Communities
 Street Address 800 W. Oakton St.
 City / State / Zip Code Arlington Heights, IL 60004
 Phone Number (847) 368-7400
 Fax Number (847) 368-7302

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	17	Administrative	Direct Allocation		\$	\$		\$ 73,214	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				\$	\$		\$ 73,214	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Paul's House & Health Care Ctr

0005165

Report Period Beginning:

07/01/08

Ending: 06/30/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number (_____

Fax Number (_____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Paul's House & Health Care Ctr

0005165

Report Period Beginning:

07/01/08

Ending: 06/30/09

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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.

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Paul's House & Health Care Ctr

0005165

Report Period Beginning:

07/01/08

Ending: 06/30/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Paul's House & Health Care Ctr

0005165

Report Period Beginning:

07/01/08

Ending: 06/30/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Paul's House & Health Care Ctr

0005165

Report Period Beginning:

07/01/08

Ending: 06/30/09

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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.

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Paul's House & Health Care Ctr

0005165

Report Period Beginning:

07/01/08

Ending: 06/30/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Paul's House & Health Care Ctr

0005165

Report Period Beginning:

07/01/08

Ending: 06/30/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Paul's House & Health Care Ctr

0005165 Report Period Beginning: 07/01/08 Ending: 06/30/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Paul's House & Health Care Ctr

0005165

Report Period Beginning:

07/01/08

Ending: 06/30/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

St Paul's House & Health Care Ctr

0005165

Report Period Beginning:

07/01/08

Ending:

06/30/09

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		8	9	10										
						Name of Lender	Related**					Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
							YES								NO	Original				Balance
	A. Directly Facility Related																			
	Long-Term																			
1	1995 Revenue Bonds		X	Financing	None	06/96	\$ 6,500,000	\$ 4,725,000	2/1/2025	Variable	\$ 70,395	1								
2	Lutheran Life Communities	X		Bed Capital Lease	\$1,230.00	6/1/08			11/30/11	0.1584	5,488	2								
3												3								
4												4								
5	See Supplemental Schedule											5								
	Working Capital																			
6	LaSalle Bank		X	Line Of Credit				100,000			9,388	6								
7												7								
8	See Supplemental Schedule											8								
9	TOTAL Facility Related				\$1,230.00		\$ 6,500,000	\$ 4,825,000			\$ 85,271	9								
	B. Non-Facility Related*																			
10	Interest Income		X								(1,492)	10								
11	Investment Income - SPF										(64,484)	11								
12												12								
13	See Supplemental Schedule											13								
14	TOTAL Non-Facility Related						\$	\$			\$ (65,976)	14								
15	TOTALS (line 9+line14)						\$ 6,500,000	\$ 4,825,000			\$ 19,295	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number

St Paul's House & Health Care Ctr

0005165

Report Period Beginning:

07/01/08

Ending:

06/30/09

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2	3	4	5	6		7	8	9	10									
						Name of Lender	Related**					Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
							YES								NO	Original				Balance
	A. Directly Facility Related																			
	Long-Term																			
1							\$	\$			\$	1								
2												2								
3												3								
4												4								
5												5								
6												6								
7	TOTAL Long-Term																			
	Working Capital																			
8							\$	\$			\$	8								
9												9								
10												10								
11												11								
12												12								
13												13								
14	TOTAL Working Capital																			
	B. Non-Facility Related*																			
15							\$	\$			\$	15								
16												16								
17												17								
18												18								
19												19								
20	TOTAL Non-Facility Related																			

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number St Paul's House & Health Care Ctr

0005165

Report Period Beginning:

07/01/08

Ending:

06/30/09

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 91,138 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 3

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)
List entity name, type of business, square footage, and number of beds/units available (where applicable).
St. Paul's Residence - 2815 W. Baron Chicago, IL 60618

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

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

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

XI. OWNERSHIP COSTS:

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Paul's House & Health Care Ctr

0005165

Report Period Beginning:

07/01/08

Ending:

06/30/09

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			1986	\$ 3,871,467	\$	20	\$ 65,530	\$ 65,530	\$ 3,871,467	4
5			1974	1,284,322		30	42,811	42,811	1,097,471	5
6			1949	332,671					332,671	6
7			1980	3,941					3,941	7
8										8
Improvement Type**										
9	Various		1976	27,003		20				9
10	Various		1978	751,898		20			735,926	10
11	Various		1981	74,417		20			74,417	11
12	Various		1982	88,065		20			87,890	12
13	Various		1984	21,915		20			21,915	13
14	Various		1985	235,600		20	902	902	226,590	14
15	Various		1986	99,966		20	914	914	90,821	15
16	Various		1987	17,045		20	492	492	12,117	16
17	Various		1988	1,500		20			1,500	17
18	Various		1989	5,140		20			5,140	18
19	Various		1990	58,255		20	2,913	2,913	56,803	19
20	Various		1991	7,167		20	425	425	5,637	20
21	Various		1992	48,661		20	2,366	2,366	25,785	21
22	Various		1994	15,410		20	465	465	13,087	22
23	Various		1995	8,236		20	413	413	5,754	23
24	Various		1996	244,921		20	12,247	12,247	115,208	24
25	Various		1997	5,967,238		20	200,717	200,717	2,557,807	25
26	Various		1998	95,528		20	3,416	3,416	63,254	26
27	Various		1999	148,127		20	6,634	6,634	80,604	27
28	Various		2000	89,166		20	4,458	4,458	40,539	28
29	Various		2001	1,596,476		20	80,521	80,521	663,390	29
30	Various		2002	37,453		20	2,846	2,846	20,059	30
31	Various		2003	105,885		20	7,690	7,690	69,097	31
32	Various		2004	53,627		20	6,700	6,700	35,535	32
33	Various		2005	42,331		20	2,464	2,464	10,564	33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67	Related Building Company (Pages 12F & 12G)							67
68	Related Party Allocations (Pages 12H & 12I)							68
69	Financial Statement Depreciation				603,157	(603,157)		69
70	TOTAL (lines 4 thru 69)	\$ 15,333,431	\$ 603,157		\$ 444,924	\$ (158,233)	\$ 10,324,989	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number St Paul's House & Health Care Ctr

0005165

Report Period Beginning:

07/01/08

Ending:

06/30/09

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		\$ 15,333,431	\$ 603,157		\$ 444,924	\$ (158,233)	\$ 10,324,989	1
2	Hvac - New Compressor	2006	15,807		20	790	790	2,370	2
3	Hvac - Thermostat, Gas Valve, Knobs	2006	639		20	32	32	96	3
4	Hvac - Low Water Cutoff	2006	1,149		20	57	57	172	4
5	Hvac - New Coplematic Compressor	2006	22,726		20	1,136	1,136	3,409	5
6	Replace Pump Housing	2007	1,908		20	95	95	286	6
7	Valve Plates For Chiller	2007	1,592		20	80	80	239	7
8	Painting Of Chapel	2007	16,159		20	808	808	1,616	8
9	Painting Of Auditorium	2007	7,785		20	389	389	779	9
10	Fire Panel Replacement	2007	10,314		20	516	516	1,031	10
11	Auditorium Carpentry & Drywall	2007	10,170		20	509	509	1,017	11
12	Roof Repairs	2007	25,000		20	1,250	1,250	2,500	12
13	Elevator - New Piping	2007	8,212		20	411	411	821	13
14	Elevator - Replace Hatch Door	2007	3,811		20	191	191	381	14
15	Carpet In Auditorium	2007	43,875		20	2,194	2,194	4,388	15
16	Restoration Of Auditorium	2007	45,018		20	2,251	2,251	4,502	16
17	Server Room Wire Closet	2007	31,906		20	1,595	1,595	3,191	17
18	Booster Heater	2007	5,900		20	295	295	590	18
19	Fire Alarm Equipment	2007	4,925		20	246	246	493	19
20	Guage Thermometers And Plumbing	2007	4,770		20	239	239	477	20
21	Landscaping Work	2007	10,690		20	535	535	1,069	21
22	Plumbing Work	2007	2,866		20	143	143	287	22
23	Air Compressors And Fans	2007	2,966		20	148	148	297	23
24	Backwater Valves	2007	5,240		20	262	262	524	24
25	Generator Annunciators	2007	4,065		20	203	203	407	25
26	Loading Dock Stairs	2007	4,700		20	235	235	470	26
27	Phone Conduits	2007	2,860		20	143	143	286	27
28	Chilled Water Pump	2008	8,985		20	449	449	899	28
29	Compressor	2008	9,485		20	474	474	949	29
30	New Drywall - Boiler Room	2008	7,120		20	356	356	712	30
31	Holby Tempering Valve	2008	25,510		20	1,276	1,276	2,551	31
32	Boiler Tubes & Installation	2008	4,843		20	242	242	484	32
33	Carpet	2008	1,665		20	167	167	333	33
34	TOTAL (lines 1 thru 33)		\$ 15,686,092	\$ 603,157		\$ 462,640	\$ (140,517)	\$ 10,362,612	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number St Paul's House & Health Care Ctr

0005165

Report Period Beginning:

07/01/08

Ending:

06/30/09

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		\$ 15,686,092	\$ 603,157		\$ 462,640	\$ (140,517)	\$ 10,362,612	1
2	Carpet Installation	2008	1,212		20	61	61	121	2
3	Aluminum Flag Pole	2008	2,187		20	109	109	219	3
4	Entrance Sign	2008	3,370		20	169	169	337	4
5	Plumbing And Concrete	2008	5,428		20	271	271	543	5
6	Generator And Actuator	2008	4,889		20	244	244	489	6
7	Wiring And Circuitry	2008	3,186		20	159	159	319	7
8	Radiator And Hose/Cables	2008	3,045		20	152	152	305	8
9	Railing And Concrete North Ada	2008	3,204		20	160	160	320	9
10	Roof Repairs	2008	1,985		20	99	99	99	10
11	Painting Of 2 East Corridores (1 Of 3)	2008	3,475		20	174	174	174	11
12	Roof Repairs	2008	1,175		20	59	59	59	12
13	Roof Repairs (Invoice 1 Of 2)	2008	417		20	21	21	21	13
14	Roof Repairs (Invoice 2 Of 2)	2008	833		20	42	42	42	14
15	Tucking Pointing Outside Accounting Office (Invoice 1 Of 2)	2008	1,000		20	50	50	50	15
16	Tucking Pointing Outside Accounting Office (Invoice 2 Of 2)	2008	2,000		20	100	100	100	16
17	New Blower Motors For 2W Dining Room Heaters	2008	3,535		20	177	177	177	17
18	Roof Repairs	2008	2,500		20	125	125	125	18
19	Painting Of 2 East Corridores (2 Of 3)	2008	2,750		20	138	138	138	19
20	Painting Of Resident Rooms # 202 & 215	2008	1,367		20	68	68	68	20
21	Painting Of Resident Room # 370	2008	406		20	20	20	20	21
22	Hot Water Recirculation Pump (Invoice 1 Of 2)	2008	896		20	45	45	45	22
23	Hot Water Recirculation Pump (Invoice 2 Of 2)	2008	1,664		20	83	83	83	23
24	Painting Of Resident Rooms # 219, 221, & 222	2008	2,257		20	113	113	113	24
25	Painting Of 2 East Corridores (3 Of 3)	2008	2,750		20	138	138	138	25
26	Painting Of Resident Rooms # 220, 224, Nurses Lounge & Confere	2008	3,130		20	157	157	157	26
27	Painting Of 2 East Nursing Station And Common Areas	2008	2,378		20	119	119	119	27
28	Painting Of 2 West Nursing Station & Half Of The Corridor	2008	2,062		20	103	103	103	28
29	Roof & Tuckpointing	2008	5,147		20	257	257	257	29
30	Interior & Exterior Painting	2008	2,655		20	133	133	133	30
31	Painting Of 2 West Corridor	2009	1,612		20	81	81	81	31
32	New Phone System (Invoice 1 Of 3)	2009	3,381		20	169	169	169	32
33	New Phone System (Invoice 2 Of 3)	2009	6,366		20	318	318	318	33
34	TOTAL (lines 1 thru 33)		\$ 15,768,354	\$ 603,157		\$ 466,753	\$ (136,404)	\$ 10,368,051	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 15,768,354	\$ 603,157		\$ 466,753	\$ (136,404)	\$ 10,368,051	1
2	New Phone System (Invoice 3 Of 3)	2009	7,895		20	395	395	395	2
3	Fire Sprinkler System Necessary Upgrades	2009	32,370		20	1,619	1,619	1,619	3
4	Replace Water Heater	2009	4,500		20	225	225	225	4
5	A/C Unit For Sph Computer Server Room - A/C Unit	2009	3,980		20	199	199	199	5
6	A/C Unit For Sph Computer Server Room - Electric Upgrade	2009	2,449		20	122	122	122	6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 15,819,548	\$ 603,157		\$ 469,313	\$ (133,844)	\$ 10,370,611	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number St Paul's House & Health Care Ctr

0005165

Report Period Beginning:

07/01/08

Ending:

06/30/09

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 15,819,548	\$ 603,157		\$ 469,313	\$ (133,844)	\$ 10,370,611	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 15,819,548	\$ 603,157		\$ 469,313	\$ (133,844)	\$ 10,370,611	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company Information								1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								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

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company Information Continued		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12F & 12G lines 1 thru 33)		\$	\$		\$	\$	\$	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information		\$	\$		\$	\$	\$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								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

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	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								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (12H & 12I lines 1 thru 33)		\$	\$		\$	\$	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number St Paul's House & Health Care Ctr

0005165

Report Period Beginning:

07/01/08

Ending:

06/30/09

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,322,989	\$	\$ 56,382	\$ 56,382	10	\$ 1,063,162	71
72	Current Year Purchases	13,535		1,353	1,353	10	1,353	72
73	Fully Depreciated Assets	1,118,898				10	1,118,898	73
74								74
75	TOTALS	\$ 2,455,422	\$	\$ 57,735	\$ 57,735		\$ 2,183,414	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	Facility	VAN	1994	\$ 37,650	\$	\$	\$	5	\$ 37,650	76
77	Facility	Bus	2007	15,000		3,000	3,000	5	9,000	77
78	Facility	Bus Paint & Repair	2007	7,796		1,559	1,559	5	3,118	78
79										79
80	TOTALS			\$ 60,446	\$	\$ 4,559	\$ 4,559		\$ 49,768	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)	\$ 18,438,495	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 603,157	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 531,607	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (71,550)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 12,603,793	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.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? YES NO

If NO, see instructions.

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

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

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

9. Option to Buy: YES NO Terms: _____*

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

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

16. Rental Amount for movable equipment: \$ 29,451 Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____/2009 \$ _____

13. _____/2010 \$ _____

14. _____/2011 \$ _____

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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	39 - 03	hrs	\$		\$ 218,268	\$		\$ 218,268	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			53,055			53,055	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			257,606			257,606	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				226,140		226,140	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental						156,804		156,804	13
14	TOTAL			\$		\$ 528,929	\$ 382,944		\$ 911,873	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **06/30/09**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 396,790	\$	1
2	Cash-Patient Deposits	31,834		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	807,965		3
4	Supply Inventory (priced at)	36,845		4
5	Short-Term Investments	2,106,706		5
6	Prepaid Insurance	(7,081)		6
7	Other Prepaid Expenses	31,054		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached Schedule</u>	79,174		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,483,287	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	108,638		13
14	Buildings, at Historical Cost	15,387,318		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	3,016,292		16
17	Accumulated Depreciation (book methods)	(11,686,020)		17
18	Deferred Charges	203,659		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule</u>	21,391		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 7,051,278	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 10,534,565	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 482,188	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	184,944		28
29	Short-Term Notes Payable	300,000		29
30	Accrued Salaries Payable	286,086		30
31	Accrued Taxes Payable (excluding real estate taxes)	7,331		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	3,811		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Attached Schedule</u>	752,048		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,016,408	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	4,525,000		41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>See Attached Schedule</u>			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 4,525,000	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 6,541,408	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,993,157	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 10,534,565	\$	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 4,420,803	1
2	Restatements (describe):		2
3	Reconciliation Entry	(6,154)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 4,414,649	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(421,492)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (421,492)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 3,993,157	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Paul's House & Health Care Ctr

0005165

Report Period Beginning: 07/01/08

Ending: 06/30/09

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

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 6,370,395	1
2	Discounts and Allowances for all Levels	(1,720,844)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,649,551	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,659,816	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,659,816	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	229	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	17,850	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	215,028	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	11,992	19
20	Radiology and X-Ray	5,056	20
21	Other Medical Services	536,580	21
22	Laundry	681	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 787,416	23
D. Non-Operating Revenue			
24	Contributions	371,213	24
25	Interest and Other Investment Income***	65,976	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 437,189	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	4,110	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 4,110	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,538,082	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,959,512	31
32	Health Care	2,100,909	32
33	General Administration	1,880,196	33
B. Capital Expense			
34	Ownership	756,094	34
C. Ancillary Expense			
35	Special Cost Centers	1,202,638	35
36	Provider Participation Fee	60,225	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,959,574	40
41	Income before Income Taxes (line 30 minus line 40)**	(421,492)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (421,492)	43

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

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

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

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

Facility Name & ID Number **St Paul's House & Health Care Ctr**

0005165

Report Period Beginning:

07/01/08

Ending:

06/30/09

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	1,818	2,110	\$ 111,290	\$ 52.74	1
2	Assistant Director of Nursing					2
3	Registered Nurses	32,544	38,219	967,885	25.32	3
4	Licensed Practical Nurses	21,304	24,711	581,101	23.52	4
5	CNAs & Orderlies	19,263	20,500	210,950	10.29	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	4,392	4,946	57,978	11.72	10
11	Social Service Workers	3,038	3,366	86,838	25.80	11
12	Dietician					12
13	Food Service Supervisor	1,287	1,362	17,558	12.89	13
14	Head Cook	5,872	6,665	94,571	14.19	14
15	Cook Helpers/Assistants	31,695	34,755	208,406	6.00	15
16	Dishwashers					16
17	Maintenance Workers	5,752	6,281	103,067	16.41	17
18	Housekeepers	17,113	18,814	173,239	9.21	18
19	Laundry	4,546	5,033	44,951	8.93	19
20	Administrator	1,913	1,988	97,757	49.17	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	14,410	15,037	367,817	24.46	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) <u>See Supplemental</u>	16,789	17,790	274,455	15.43	33
34	TOTAL (lines 1 - 33)	181,736	201,577	\$ 3,397,863 *	\$ 16.86	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	1,310	\$ 55,533	01-03	35
36	Medical Director	Monthly	12,000	09-03	36
37	Medical Records Consultant	Monthly	1,421	10-03	37
38	Nurse Consultant	Bi -Montly	990	10-03	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	1,611	11-03	44
45	Social Service Consultant	210	9,660	12-03	45
46	Other(specify) <u>Rehab</u>	Hourly	14,482	10a-03	46
47	<u>Chaplain</u>	Monthly	7,780	12-03	47
48	<u>Contracted Services Dietary</u>		182,082	01-03	48
49	TOTAL (lines 35 - 48)	1,520	\$ 285,559		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	491	\$ 24,564	10-03	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	491	\$ 24,564		53

SEE ACCOUNTANTS' COMPILATION REPORT

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	
Mary Grondin 07/01/08 - 08/24/08	Administrator	0	\$ 18,725	Workers' Compensation Insurance	\$ 153,187	IDPH License Fee	\$	
Eliana Casella 08/25/08 - 06/30/09	Administrator	0	79,032	Unemployment Compensation Insurance	46,469	Advertising: Employee Recruitment	17,496	
				FICA Taxes	243,078	Health Care Worker Background Check		
				Employee Health Insurance	236,170	(Indicate # of checks performed <u>49</u>)	590	
				Employee Meals	17,754	Patient Background Checks	1,780	
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	7,840	
				Dental Insurance	2,652	Inspection Fees & Permits	5,188	
				Retirement Benefits	53,763	LSN Dues	7,932	
				Life Insurance	7,360	Yellow Page Advertising	5,374	
				Drug Screening	5,560	Advertising	24,223	
				Disability Insurance	2,905	Less: Public Relations Expense	(4,549)	
						Non-allowable advertising	(24,222)	
						Yellow page advertising	(5,374)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)						TOTAL (agree to Sch. V, line 20, col. 8)		
\$ 97,757				\$ 768,898			\$ 36,278	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description	Amount			Description	Line #	Amount	Description	Amount
Lutheran Life Communities - Admin Expenses	\$ 73,214					\$	Out-of-State Travel	\$
							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				TOTAL			Seminar Expense	
\$ 73,214				\$			5,534	
C. Professional Services							Entertainment Expense	
Vendor/Payee	Type	Amount					(agree to Sch. V, line 24, col. 8)	
Locke Lord Bissell & Liddell LLP	Legal (Adj. on 5a)	\$ 1,584					TOTAL	
Steven Katz	Accounting Services	19,711					\$ 5,534	
FORTUNE	Recruiting Services	11,300						
Frost, Ruttenberg and Rothblatt	Accounting/Consulting	6,100						
Glifton Gunderson LLP	Audit	10,664						
Elizabeth Walp	HR Consulting	21,369						
Hennelley, Jacob, & Quinlin Assoc.	Operational Consulting	1,000						
Fomark Companies LLC	Interim Administrator	18,839						
Continuum Development Servs.	Operational Consulting	34,784						
Method Management	Mock Survey	2,500						
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)				\$ 127,851				

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013
1	N.A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Paul's House & Health Care Ctr

0005165

Report Period Beginning: 07/01/08

Ending: 06/30/09

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. \$5,508.6 Life Services Network
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 46,227 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. \$ 60,225
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, 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. \$ 17,754 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 17,850
- (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% Ln 14
- d. Have vehicle usage logs been maintained? Yes
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? 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. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: KPMG 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? N/A
Attach invoices and a summary of services for all architect and appraisal fees.