

Facility Name & ID Number St Pauls Home

0013920 Report Period Beginning: 1/01/2015 Ending: 12/31/2015

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 8/10/15

	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	78	Skilled (SNF)	90	27,636	1
2		Skilled Pediatric (SNF/PED)			2
3	35	Intermediate (ICF)	35	12,775	3
4		Intermediate/DD			4
5	40	Sheltered Care (SC)	40	14,600	5
6		ICF/DD 16 or Less			6
7	153	TOTALS	165	55,011	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	Total	
8	SNF	10,328	9,568	3,652	23,548	8
9	SNF/PED					9
10	ICF	3,430	3,447		6,877	10
11	ICF/DD					11
12	SC		4,951		4,951	12
13	DD 16 OR LESS					13
14	TOTALS	13,758	17,966	3,652	35,376	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 64.31%

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

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

Outpatient therapy services to ILU, SC/SH Residents

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 90 and days of care provided 3,652

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: 12/31/2015 Fiscal Year: 12/31/2015

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

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	421,916	46,416	13,167	481,499		481,499	(6,121)	475,378		1
2	Food Purchase		284,185		284,185		284,185		284,185		2
3	Housekeeping	182,680	22,105		204,785		204,785		204,785		3
4	Laundry	95,239	13,318		108,557		108,557		108,557		4
5	Heat and Other Utilities			264,489	264,489		264,489		264,489		5
6	Maintenance	82,596	950	43,656	127,202		127,202		127,202		6
7	Other (specify):* Trash			23,122	23,122		23,122		23,122		7
8	TOTAL General Services	782,431	366,974	344,434	1,493,839		1,493,839	(6,121)	1,487,718		8
	B. Health Care and Programs										
9	Medical Director			10,200	10,200		10,200		10,200		9
10	Nursing and Medical Records	2,262,887	21,155	130,978	2,415,020		2,415,020	(138,878)	2,276,142		10
10a	Therapy										10a
11	Activities	70,949	10,403		81,352		81,352		81,352		11
12	Social Services	41,393			41,393		41,393		41,393		12
13	CNA Training										13
14	Program Transportation	13,988		1,332	15,320		15,320		15,320		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,389,217	31,558	142,510	2,563,285		2,563,285	(138,878)	2,424,407		16
	C. General Administration										
17	Administrative	87,692			87,692		87,692		87,692		17
18	Directors Fees										18
19	Professional Services			596,040	596,040		596,040		596,040		19
20	Dues, Fees, Subscriptions & Promotions			96,068	96,068		96,068	(67,817)	28,251		20
21	Clerical & General Office Expenses	284,912	19,149	233,599	537,660		537,660	(174,182)	363,478		21
22	Employee Benefits & Payroll Taxes			874,868	874,868		874,868		874,868		22
23	Inservice Training & Education										23
24	Travel and Seminar			7,081	7,081		7,081		7,081		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			79,208	79,208		79,208		79,208		26
27	Other (specify):*										27
28	TOTAL General Administration	372,604	19,149	1,886,864	2,278,617		2,278,617	(241,999)	2,036,618		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,544,252	417,681	2,373,808	6,335,741		6,335,741	(386,998)	5,948,743		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.

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			458,684	458,684		458,684		458,684			30
31	Amortization of Pre-Op. & Org.			74,763	74,763		74,763		74,763			31
32	Interest			465,136	465,136		465,136	(1,357)	463,779			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			13,301	13,301		13,301		13,301			35
36	Other (specify):*											36
37	TOTAL Ownership			1,011,884	1,011,884		1,011,884	(1,357)	1,010,527			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		231,887	591,603	823,490		823,490		823,490			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			225,925	225,925		225,925		225,925			42
43	Other (specify):* Assisted Living	292,592	12,670	866,640	1,171,902		1,171,902	(1,171,902)				43
44	TOTAL Special Cost Centers	292,592	244,557	1,684,168	2,221,317		2,221,317	(1,171,902)	1,049,415			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,836,844	662,238	5,069,860	9,568,942		9,568,942	(1,560,257)	8,008,685			45

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

Facility Name & ID Number St Pauls Home

0013920

Report Period Beginning: 1/01/2015

Ending: 12/31/2015

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	(6,121)	1		4
5	Telephone, TV & Radio in Resident Rooms	(18,689)	21		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	(1,357)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(78,173)	21		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	(75,418)	21		24
25	Fund Raising, Advertising and Promotional	(67,817)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule SEE PG5A	(1,312,682)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,560,257)		\$	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))	\$ (1,560,257)		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

St Pauls Home

ID# 0013920

Report Period Beginning: 1/01/2015

Ending: 12/31/2015

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Vending Income	\$ (1,852)	21	1
2	Other Income	(138,878)	10	2
3	Assisted Living Expenses	(1,171,902)	43	3
4	Telephone Income	(50)	21	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				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	(1,312,682)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number St Pauls Home# 0013920

Report Period Beginning:

1/01/2015

Ending:

12/31/2015

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	(6,121)	0	0	0	0	0	0	0	0	0	0	(6,121)	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	TOTAL General Services	(6,121)	0	(6,121)	8									
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(138,878)	0	0	0	0	0	0	0	0	0	0	(138,878)	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	TOTAL Health Care and Programs	(138,878)	0	(138,878)	16									
	C. General Administration													
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	(67,817)	0	0	0	0	0	0	0	0	0	0	(67,817)	20
21	Clerical & General Office Expenses	(174,182)	0	0	0	0	0	0	0	0	0	0	(174,182)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(241,999)	0	(241,999)	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(386,998)	0	(386,998)	29									

STATE OF ILLINOIS

Facility Name & ID Number St Pauls Home

0013920

Report Period Beginning:

1/01/2015 Ending:

Summary B

12/31/2015

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,357)	0	0	0	0	0	0	0	0	0	0	(1,357)	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	TOTAL Ownership	(1,357)	0	0	0	0	0	0	0	0	0	0	(1,357)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	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):*	(1,171,902)	0	0	0	0	0	0	0	0	0	0	(1,171,902)	43
44	TOTAL Special Cost Centers	(1,171,902)	0	0	0	0	0	0	0	0	0	0	(1,171,902)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(1,560,257)	0	0	0	0	0	0	0	0	0	0	(1,560,257)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Board Listing at PG6-Supp						

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: 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 Pauls Home

0013920

Report Period Beginning:

1/01/2015

Ending:

12/31/2015

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Dennis Spencer	BOD						1
2	Kristine Mueller	BOD						2
3	Beverly Brightwell	BOD						3
4	Betty Leppard	BOD						4
5	Rev. Andrew Kramer	BOD						5
6	Al Scharf	BOD						6
7	Jason Karstens	BOD						7
8	Bob DeCamp	BOD						8
9	Craig Brethauer	BOD						9
10	Margaret Lowery	BOD						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

Facility Name & ID Number St Pauls Home # 0013920 Report Period Beginning: 1/01/2015 Ending: 12/31/2015

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference
						Hours	Percent	Description	Amount	
1	N/A								\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

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

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

Facility Name & ID Number St Pauls Home

0013920 Report Period Beginning: 1/01/2015

Ending: 2/31/2015

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

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	Name of Lender	2		3	4	5	6		8	9	10						
		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	First Bank		X	Note Payable Term Loan	\$104,802.87	12/10/13	\$ 21,600,000	\$ 20,587,253	5/31/16	0.0500	\$ 337,354	1					
2	The Good Samaritan Independent Liv	X		Subordinated Loan Payable	varies	12/10/13	3,500,000	3,500,000	12/10/26	0.0700	195,762	2					
3	St. Andrew's Resources for Seniors	X		Subordinated Loan Payable	varies	12/10/13	1,500,000	1,500,000	12/10/26	0.0700	328,598	3					
4												4					
5												5					
Working Capital																	
6												6					
7												7					
8												8					
9	TOTAL Facility Related				\$104,802.87		\$ 26,600,000	\$ 25,587,253			\$ 861,714	9					
B. Non-Facility Related*																	
10												10					
11												11					
12												12					
13												13					
14	TOTAL Non-Facility Related						\$	\$			\$	14					
15	TOTALS (line 9+line14)						\$ 26,600,000	\$ 25,587,253			\$ 861,714	15					

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

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>																																					
1. Real Estate Tax accrual used on 2014 report.		\$	1																																		
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	2																																		
3. Under or (over) accrual (line 2 minus line 1).		\$	3																																		
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	4																																		
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5																																		
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6																																		
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	7																																		
Real Estate Tax History:																																					
Real Estate Tax Bill for Calendar Year:	<table border="1"> <tr><td>2010</td><td>_____</td><td>8</td></tr> <tr><td>2011</td><td>_____</td><td>9</td></tr> <tr><td>2012</td><td>_____</td><td>10</td></tr> <tr><td>2013</td><td>_____</td><td>11</td></tr> <tr><td>2014</td><td>_____</td><td>12</td></tr> </table>	2010	_____	8	2011	_____	9	2012	_____	10	2013	_____	11	2014	_____	12	<table border="1"> <tr><td colspan="2">FOR BHF USE ONLY</td><td></td></tr> <tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2014</td><td>\$</td><td>13</td></tr> <tr><td>14</td><td>PLUS APPEAL COST FROM LINE 5</td><td>\$</td><td>14</td></tr> <tr><td>15</td><td>LESS REFUND FROM LINE 6</td><td>\$</td><td>15</td></tr> <tr><td>16</td><td>AMOUNT TO USE FOR RATE CALCULATION</td><td>\$</td><td>16</td></tr> </table>		FOR BHF USE ONLY			13	FROM R. E. TAX STATEMENT FOR 2014	\$	13	14	PLUS APPEAL COST FROM LINE 5	\$	14	15	LESS REFUND FROM LINE 6	\$	15	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16
2010	_____	8																																			
2011	_____	9																																			
2012	_____	10																																			
2013	_____	11																																			
2014	_____	12																																			
FOR BHF USE ONLY																																					
13	FROM R. E. TAX STATEMENT FOR 2014	\$	13																																		
14	PLUS APPEAL COST FROM LINE 5	\$	14																																		
15	LESS REFUND FROM LINE 6	\$	15																																		
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16																																		

NOTES:

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

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME St Pauls 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 2014 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 2014.

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

B. Real Estate Tax Cost Allocations

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

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

C. **Tax Bills**

Attach a copy of the original 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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 Pauls Home

0013920 Report Period Beginning:

1/01/2015 Ending:

12/31/2015

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 90,492 B. General Construction Type: Exterior Brick, Vinyl Frame _____ Number of Stories _____

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 consists of 90 skilled beds, 26 shelter beds, 18 memory care beds, and 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>\$ 22,696</u>	1
2					2
3	TOTALS	178,000		\$ 22,696	3

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	90	2015	2015	\$ 16,977,488	\$ 184,014	40	\$ 184,014	\$	\$ 184,014	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	1981 IMPROVEMENTS		1981	10,965		15			10,965	9
10	1982 IMPROVEMENTS		1982	3,200		15			3,200	10
11	1983 IMPROVEMENTS		1983	4,380		15			4,380	11
12	1987 IMPROVEMENTS		1987	112,643	28,517	VARIOUS	28,517		112,643	12
13	1996 IMPROVEMENTS		1996	19,617		VARIOUS			19,617	13
14	1997 IMPROVEMENTS		1997	12,290		VARIOUS			12,290	14
15	SNF Building - Tools & Equipment		2015	15,473	921	7	921		921	15
16	SNF Building - Asphalt Paving		2015	167,386	8,718	8	8,718		8,718	16
17	SNF Building - Landscaping and Irrigation		2015	209,910	8,746	10	8,746		8,746	17
18	SNF Building - Carpentry		2015	273,402	7,595	15	7,595		7,595	18
19	SNF Building - General Door Openings		2015	754,955	15,728	20	15,728		15,728	19
20	SNF Building - Automatic Doors & Operators		2015	11,666	486	10	486		486	20
21	SNF Building - Ceramic Tile		2015	299,865	6,247	20	6,247		6,247	21
22	SNF Building - Flooring		2015	368,589	7,679	20	7,679		7,679	22
23	SNF Building - Painting & Wallcovering		2015	298,517	24,876	5	24,876		24,876	23
24	SNF Building - Residential Appliances		2015	136,074	5,670	10	5,670		5,670	24
25	SNF Building - Commercial Laundry Equipment		2015	51,208	1,422	15	1,422		1,422	25
26	SNF Building - HVAC		2015	1,710,935	35,645	20	35,645		35,645	26
27	SNF Building - Plumbing		2015	1,345,918	28,040	20	28,040		28,040	27
28	Costs of Issuance (Construction Draws)		2015	273,314	2,847	40	2,847		2,847	28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number St Pauls Home

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 23,057,795	\$ 367,151		\$ 367,151	\$	\$ 501,729	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 249,574	\$ 91,409	\$ 91,409	\$		\$ 239,374	71
72	Current Year Purchases	1,214,625						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,464,199	\$ 91,409	\$ 91,409	\$		\$ 239,374	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Van	Ford Econoline 1992	1993	\$ 550	\$	\$	\$		\$ 550	76
77	Van Improvements	Econoline Van Life '92	'95, '96, '97	18,395					18,395	77
78	Patient Transport	Buick LeSabre 1995	2009	15,329				7	10,949	78
79	Patient Transport	Chevy Impala 2006	2009	16,505	124	124		7	11,790	79
80	TOTALS			\$ 50,779	\$ 124	\$ 124	\$		\$ 41,684	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)	\$ 24,595,469	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 458,684	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 458,684	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)	\$ 782,787	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	Apartment Land	\$ 83,097	\$	\$	86
87	Apartment Building	5,444,480	141,550	3,375,358	87
88	Apartment Equip & Comp	281,401	4,035	263,727	88
89	Apartment Vehicles	34,262		34,262	89
90					90
91	TOTALS	\$ 5,843,240	\$ 145,585	\$ 3,673,347	91

G. Construction-in-Progress

	Description	Cost	
92	New Building 2015	\$ 913,029	92
93	Capitalized Interest	72,926	93
94	Deferred Marketing	15,290	94
95		\$ 1,001,245	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.

Facility Name & ID Number St Pauls Home

0013920

Report Period Beginning: 1/01/2015

Ending: 12/31/2015

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 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

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. _____ /2016 \$ _____

13. _____ /2017 \$ _____

14. _____ /2018 \$ _____

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: \$ 13,301 Description: Copier

(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

* 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.

Facility Name & ID Number St Pauls Home # 0013920 Report Period Beginning: 1/01/2015 Ending: 12/31/2015
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?</p> <p><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. CLASSROOM PORTION:</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. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	V10A-3	hrs	\$	3,142	\$ 179,061	\$	3,142	\$ 179,061	1	
2	Licensed Speech and Language Development Therapist	V10A-3	hrs		10,308	140,825		10,308	140,825	2	
3	Licensed Recreational Therapist		hrs							3	
4	Licensed Physical Therapist	V10A-3	hrs		4,609	223,208		4,609	223,208	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	Other (specify):									12	
13	Other (specify):									13	
14	TOTAL			\$	18,059	\$ 543,094	\$	18,059	\$ 543,094	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 Pauls Home# 0013920Report Period Beginning: 1/01/2015Ending: 12/31/2015

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2015 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 692,594	\$	1
2	Cash-Patient Deposits	45,470		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>557,387</u>)	1,791,255		3
4	Supply Inventory (priced at)	19,403		4
5	Short-Term Investments	30,064		5
6	Prepaid Insurance	105,240		6
7	Other Prepaid Expenses	14,361		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Other Current Assets</u>	664,415		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,362,802	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	22,696		13
14	Buildings, at Historical Cost	22,894,700		14
15	Leasehold Improvements, at Historical Cost	163,095		15
16	Equipment, at Historical Cost	1,514,978		16
17	Accumulated Depreciation (book methods)	(782,787)		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 <u>CIP</u>)	1,001,245		22
23	Other(specify): <u>Assisted Living</u>	2,169,893		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 26,983,820	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 30,346,622	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 734,007	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	43,103		28
29	Short-Term Notes Payable	355,469		29
30	Accrued Salaries Payable	231,598		30
31	Accrued Taxes Payable (excluding real estate taxes)	16,963		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	740,491		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>CIP Not Yet Drawn on Loan</u>	148,542		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,270,173	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	25,315,918		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Assisted Living</u>	135,875		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 25,451,793	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 27,721,966	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 2,624,656	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 30,346,622	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 4,291,149	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 4,291,149	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(1,666,493)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (1,666,493)	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)	\$ 2,624,656	24 *

* 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	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 6,475,338	1
2	Discounts and Allowances for all Levels	(1,531,578)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,943,760	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,447,113	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,447,113	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	6,121	14
15	Telephone, Television and Radio	50	15
16	Rental of Facility Space		16
17	Sale of Drugs	96,710	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	684	19
20	Radiology and X-Ray	3,662	20
21	Other Medical Services	38,137	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 145,364	23
D. Non-Operating Revenue			
24	Contributions	204,000	24
25	Interest and Other Investment Income***	12,978	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 216,978	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Other Revenue/Losses	(79,481)	28
28a	AL Revenue	1,228,715	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,149,234	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,902,449	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,493,839	31
32	Health Care	2,563,285	32
33	General Administration	2,278,617	33
B. Capital Expense			
34	Ownership	1,011,884	34
C. Ancillary Expense			
35	Special Cost Centers	1,995,392	35
36	Provider Participation Fee	225,925	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,568,942	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,666,493)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,666,493)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,747,559	44
45	Private Pay - Net Inpatient Revenue	2,945,202	45
46	Medicare - Net Inpatient Revenue	622,698	46
47	Other-(specify) <u>Charity Write-offs</u>	(237,140)	47
48	Other-(specify) <u>New Bldg Discount</u>	(134,559)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,943,760	49

* 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.

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

Facility Name & ID Number **St Pauls Home**

0013920

Report Period Beginning:

1/01/2015

Ending:

12/31/2015

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,080	2,080	\$ 83,255	\$ 40.03	1
2	Assistant Director of Nursing	1,213	1,213	31,383	25.87	2
3	Registered Nurses	6,251	6,251	159,279	25.48	3
4	Licensed Practical Nurses	29,286	29,286	705,961	24.11	4
5	CNAs & Orderlies	83,466	83,466	1,104,231	13.23	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	6,310	6,310	70,949	11.24	10
11	Social Service Workers	1,935	1,935	41,393	21.39	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	28,412	28,412	421,916	14.85	15
16	Dishwashers					16
17	Maintenance Workers	7,659	7,659	96,584	12.61	17
18	Housekeepers	22,676	22,676	182,680	8.06	18
19	Laundry	8,543	8,543	95,239	11.15	19
20	Administrator	2,080	2,080	87,692	42.16	20
21	Assistant Administrator					21
22	Other Administrative	13,860	13,860	365,053	26.34	22
23	Office Manager					23
24	Clerical					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	3,917	3,917	39,607	10.11	31
32	Other Health C: MDS Coordinator	2,080	2,080	59,030	28.38	32
33	Other(specify) <u>Assisted Living</u>	19,937	19,937	292,592	14.68	33
34	TOTAL (lines 1 - 33)	239,705	239,705	\$ 3,836,844 *	\$ 16.01	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	\$		35
36	Medical Director			36
37	Medical Records Consultant			37
38	Nurse Consultant			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			44
45	Social Service Consultant			45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$		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

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	
Sharrill Kruep	EXEC DIR	0	\$ 87,692	Workers' Compensation Insurance	\$ 280,864	IDPH License Fee	\$ 5,557	
				Unemployment Compensation Insurance	35,223	Advertising: Employee Recruitment	8,607	
				FICA Taxes	266,564	Health Care Worker Background Check		
				Employee Health Insurance	289,663	(Indicate # of checks performed <u>127</u>)	2,030	
				Employee Meals		Resident Background Checks <u>116</u>	1,860	
				Illinois Municipal Retirement Fund (IMRF)*		Employee Events	2,482	
				Life Insurance	2,554	Dues & Subscriptions	7,715	
						Public Relations	67,817	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 87,692					
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)	
Description			Amount		\$ 874,868	Less: Public Relations Expense	(67,817)	
			\$			Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$			TOTAL (agree to Sch. V, line 20, col. 8)		
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Lowenbaum	HR		\$ 1,300			\$	Out-of-State Travel	\$
Mathis, Mari, Richter	Legal Services		69,939					
Daniel Maher Law	Legal Services		17,960				In-State Travel	1,486
Other	Legal Services		1,390					
ADP	Payroll Processing		14,285				Seminar Expense	5,595
St. Andrew's Mgmt Services	Management Fee		338,479					
St. Andrew's Mgmt Services	IT & Computer Fees		114,851				Entertainment Expense	()
BKD LLP	Audit, Tax, Cost Report		37,836					
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 596,040	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ 7,081

* 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	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number St Pauls Home

0013920

Report Period Beginning:

1/01/2015

Ending:

12/31/2015

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. Leading Age \$7,714.74
- (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 YRS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 34,362 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. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 225,925
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? 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. \$ 0 Has any meal income been offset against related costs? No Indicate the amount. \$ 0
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 0
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: CliftonLarsonAllen LLP
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees.