



Facility Name & ID Number St Pauls House & Hlth Cr Ctr

# 0005165 Report Period Beginning: 7/01/2014 Ending: 6/30/2015

**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 \_\_\_\_\_

	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 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	9,260	10,808	10,646	30,714	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC		16,780		16,780	12
13	DD 16 OR LESS					13
14	TOTALS	9,260	27,588	10,646	47,494	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 73.10%

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 10,646

Medicare Intermediary National Government Services

**IV. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 6/30/2015 Fiscal Year: 6/30/2015

\* 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
	<b>A. General Services</b>										
1	Dietary	607,394	3	54,650	662,047		662,047	662,047		1	
2	Food Purchase		409,039		409,039		409,039	(57,386)	351,653	2	
3	Housekeeping	210,263	49,331	31	259,625		259,625	259,625		3	
4	Laundry	63,142	5,309	5,072	73,523		73,523	(830)	72,693	4	
5	Heat and Other Utilities			330,394	330,394		330,394	330,394		5	
6	Maintenance	195,153	45,579	230,180	470,912		470,912	470,912		6	
7	Other (specify):* Security	58,203			58,203		58,203	58,203		7	
8	<b>TOTAL General Services</b>	<b>1,134,155</b>	<b>509,261</b>	<b>620,327</b>	<b>2,263,743</b>		<b>2,263,743</b>	<b>(58,216)</b>	<b>2,205,527</b>	<b>8</b>	
	<b>B. Health Care and Programs</b>										
9	Medical Director			22,800	22,800		22,800	22,800		9	
10	Nursing and Medical Records	3,042,781	1,391	264,239	3,308,411		3,308,411	(15,887)	3,292,524	10	
10a	Therapy									10a	
11	Activities	169,167	2,303	15,679	187,149		187,149	187,149		11	
12	Social Services	87,783		5,579	93,362		93,362	93,362		12	
13	CNA Training									13	
14	Program Transportation									14	
15	Other (specify):*									15	
16	<b>TOTAL Health Care and Programs</b>	<b>3,299,731</b>	<b>3,694</b>	<b>308,297</b>	<b>3,611,722</b>		<b>3,611,722</b>	<b>(15,887)</b>	<b>3,595,835</b>	<b>16</b>	
	<b>C. General Administration</b>										
17	Administrative	72,999		600,000	672,999		672,999	672,999		17	
18	Directors Fees									18	
19	Professional Services			95,841	95,841		95,841	95,841		19	
20	Dues, Fees, Subscriptions & Promotions			51,886	51,886		51,886	51,886		20	
21	Clerical & General Office Expenses	403,604	13,259	330,686	747,549		747,549	(291,822)	455,727	21	
22	Employee Benefits & Payroll Taxes			1,150,307	1,150,307		1,150,307	1,150,307		22	
23	Inservice Training & Education									23	
24	Travel and Seminar			40,057	40,057		40,057	(29,395)	10,662	24	
25	Other Admin. Staff Transportation									25	
26	Insurance-Prop.Liab.Malpractice			167,820	167,820		167,820	167,820		26	
27	Other (specify):*									27	
28	<b>TOTAL General Administration</b>	<b>476,603</b>	<b>13,259</b>	<b>2,436,597</b>	<b>2,926,459</b>		<b>2,926,459</b>	<b>(321,217)</b>	<b>2,605,242</b>	<b>28</b>	
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>4,910,489</b>	<b>526,214</b>	<b>3,365,221</b>	<b>8,801,924</b>		<b>8,801,924</b>	<b>(395,320)</b>	<b>8,406,604</b>	<b>29</b>	

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.  
 NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

## 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	
	<b>D. Ownership</b>											
30	Depreciation			788,682	788,682		788,682		788,682			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			295,146	295,146		295,146	(8,181)	286,965			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			80,938	80,938		80,938		80,938			35
36	Other (specify):* <b>Amort Def Financing</b>											36
37	<b>TOTAL Ownership</b>			1,164,766	1,164,766		1,164,766	(8,181)	1,156,585			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		499,206	1,531,952	2,031,158		2,031,158		2,031,158			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			181,680	181,680		181,680		181,680			42
43	Other (specify):* <b>Marketing/AL/IL</b>	931,074	27,115	287,276	1,245,465		1,245,465	(1,245,465)				43
44	<b>TOTAL Special Cost Centers</b>	931,074	526,321	2,000,908	3,458,303		3,458,303	(1,245,465)	2,212,838			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	5,841,563	1,052,535	6,530,895	13,424,993		13,424,993	(1,648,966)	11,776,027			45

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

**VI. ADJUSTMENT DETAIL**

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(39,095)	2		4
5	Telephone, TV & Radio in Resident Rooms	(32,572)	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	(8,181)	32		10
11	Discounts, Allowances, Rebates & Refunds	(23,233)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(29,395)	24		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	(205,354)	21		24
25	Fund Raising, Advertising and Promotional				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 Other Non-allowable	(1,311,136)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (1,648,966)</b>		<b>\$</b>	<b>30</b>

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$</b>		<b>36</b>
	(sum of SUBTOTALS)			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	<b>\$ (1,648,966)</b>		<b>37</b>

\*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	<b>TOTAL (C): (sum of lines 38-46)</b>			<b>\$</b>		<b>47</b>

BHF USE ONLY						
48		49		50		51
						52

St Pauls House & Hlth Cr Ctr

ID# 0005165

Report Period Beginning: 7/01/2014

Ending: 6/30/2015

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Miscellaneous Income	\$ (6,036)	21	1
2	Miscellaneous Income - Nursing	(15,887)	10	2
3				3
4	AL/Foundation/Marketing Salaries	(931,074)	43	4
5	AL/Foundation/Marketing Supplies	(27,115)	43	5
6	AL/Foundation/Marketing Other	(287,276)	43	6
7	Other Revenue	(23,855)	21	7
8	Laundry Income	(830)	4	8
9				9
10	Beauty & Barber Income	(772)	21	10
11				11
12	Dining Discounts	(18,291)	2	12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(1,311,136)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number St Pauls House & Hlth Cr Ctr# 0005165

Report Period Beginning:

7/01/2014

Ending:

6/30/2015

## 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	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(57,386)	0	0	0	0	0	0	0	0	0	0	(57,386)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(830)	0	0	0	0	0	0	0	0	0	0	(830)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(58,216)</b>	<b>0</b>	<b>(58,216)</b>	<b>8</b>									
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(15,887)	0	0	0	0	0	0	0	0	0	0	(15,887)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>(15,887)</b>	<b>0</b>	<b>(15,887)</b>	<b>16</b>									
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(291,822)	0	0	0	0	0	0	0	0	0	0	(291,822)	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	(29,395)	0	0	0	0	0	0	0	0	0	0	(29,395)	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	<b>TOTAL General Administration</b>	<b>(321,217)</b>	<b>0</b>	<b>(321,217)</b>	<b>28</b>									
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(395,320)</b>	<b>0</b>	<b>(395,320)</b>	<b>29</b>									

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number St Pauls House & Hlth Cr Ctr# 0005165

Report Period Beginning:

7/01/2014 Ending:6/30/2015

## 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)	
	<b>D. Ownership</b>													
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	(8,181)	0	0	0	0	0	0	0	0	0	0	(8,181)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(8,181)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(8,181)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(1,245,465)	0	0	0	0	0	0	0	0	0	0	(1,245,465)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(1,245,465)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(1,245,465)</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(1,648,966)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(1,648,966)</b>	<b>45</b>

**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
Lutheran Home for the Aged Inc.	100	Lutheran Home for the Aged	Arlington Heights	Lutheran Life Ministr	Arlington Heights	Parent Holding Cor
		Pleasant View Luther Home	Ottawa	Lutheran Life Commu	Arlington Heights	Management Consu
		St. Pauls House & Health Care Center	Chicago	Lutheran Foundation	Arlington Heights	Fundraising
		Wittenberg Lutheran Village	Crown Point	Lutheran Community	Arlington Heights	Support Services
		Arlington of Naples (under Construction)	Naples			
		Luthe Oaks	Bloomington			

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		
	V	17	Administrative Expenses	\$ 600,000	Lutheran Life Communities	0.00%	\$ 600,000	\$
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		\$ 600,000			\$ 600,000	\$ *	14

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

Facility Name & ID Number St Pauls House & Hlth Cr Ctr # 0005165 Report Period Beginning: 7/01/2014 Ending: 6/30/2015

## 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	Roger Paulsberg	Chairman	Administrative	0.00	294,821	3	7.50	Salary	\$ 23,904	17-3	1
2	Jim Holbrook	Vice President	Administrative	0.00	228,525	2	4.88	Salary	11,719	17-3	2
3	Carl Moellenkamp	Treasurer	Administrative	0.00	98,379	10	17.86	Salary	21,387	17-3	3
4	Lori Fedyk	Treasurer	Administrative	0.00	139,089	6	15.00	Salary	24,545	17-3	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 81,555		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 House & Hlth Cr Ctr

# 0005165

Report Period Beginning:

7/01/2014

Ending:

/30//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

Lutheran Life Communities

Street Address

800 W. Oakton

City / State / Zip Code

Arlington Heights, IL60004

Phone Number

(847)368-7400

Fax Number

(847) 368-7302

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	17	Administrative	Direct Allocation		\$	\$		\$ 600,000	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				\$	\$		\$ 600,000	25



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

**B. Real Estate Taxes**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>			
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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>	\$			5
6.	Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>	\$			6
7.	Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$			7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2010	_____	8	
		2011	_____	9	
		2012	_____	10	
		2013	_____	11	
		2014	_____	12	
<b>FOR BHF USE ONLY</b>					
		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 House & Hlth Cr Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0005165

CONTACT PERSON REGARDING THIS REPORT N/A

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

**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?      X   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 House & Hlth Cr Ctr

# 0005165 Report Period Beginning:

7/01/2014 Ending:

6/30/2015

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 91,138 B. General Construction Type: Exterior Brick Frame Brick 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 Pauls Resident, 2815 W. Byron, 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:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>		<u>1910</u>	<u>\$ 103,081</u>	1
2					2
3	<b>TOTALS</b>			<b>\$ 103,081</b>	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		1986	1986	\$ 3,871,467	\$		\$	\$	\$
5		1974	1974	1,311,772					
6		1949	1949	440,643					
7									
8									
<b>Improvement Type**</b>									
9	Various		1972	2,363					
10	Various		1974	4,970					
11	Various		1975	2,390					
12	Various		1977	3,525					
13	Various		1979	560,281					
14	Various		1980	74,338					
15	Various		1981	3,653					
16	Various		1982	157,205					
17	Various		1983	5,074					
18	Various		1985	219,385					
19	Various		1986	60,006					
20	Various		1987	4,370					
21	Various		1988	1,500					
22	Various		1990	5,140					
23	Various		1991	58,255					
24	Various		1992	2,200					
25	Various		1993	8,500					
26	Various		1995	17,542					
27	Various		1996	57,995					
28	Various		1997	6,258,224					
29	Various		1998	164,984					
30	Various		1999	60,741					
31	Various		2000	56,821					
32	Various		2001	1,607,817					
33	Various		2002	17,908					
34	Various		2004	39,650					
35	Various		2008	229,668					
36	Various		2009	78,931					

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

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

See Page 12A, Line 70 for total

Facility Name &amp; ID Number St Pauls House &amp; Hlth Cr Ctr

# 0005165

Report Period Beginning:

7/01/2014

Ending:

6/30/2015

**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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Various	2010	\$ 646,431	\$		\$	\$	\$	37
38	SPH Shelter Care Carpeting Ro	2011	1,690						38
39	Shelter Care Carpet Rooms 26	2011	4,258						39
40	East Building HVAC Unit Engee	2011	7,423						40
41	East AC Unit 1 of 3	2011	60,333						41
42	East AC Unit Electric	2011	14,850						42
43	1 East Chiller Breathing Mask	2011	1,375						43
44	East Chiller West Town 2 of 3	2011	54,670						44
45	East Chiller Final Electric Paym	2011	14,850						45
46	Eash Chiller West Town 3 of 3	2011	41,847						46
47	Stairwell Railing Additions	2012	16,850						47
48	Carpet for 1st and 2nd Floor in	2012	22,460						48
49	East Chiller West Town	2012	25,000						49
50	SPH Chiller System	2012	5,446						50
51	Carpet for 1st and 2nd floor in S	2012	22,460						51
52	2 East Redecoration - Architect	2013	2,500						52
53	Hot Water Tanks	2013	27,925						53
54	2 East - Architect Fees	2013	2,640						54
55	Voice/Data Cabling Project #1	2013	92,000						55
56	Wireless Project #1	2013	75,757						56
57	3rd Floor Memory Support - Re	2013	1,790						57
58	3rd Floor/ 2 East Project - Attor	2013	8,599						58
59	3rd FI MSAL Relocation 1	2013	785						59
60	3rd FI MSAL Carpeting for Relo	2013	4,696						60
61	MIF Loan Interest April	2013	15,751						61
62	2E/3FI MSAL Henkel Performa	2013	4,428						62
63	2E Henkel Electric 1	2013	30,000						63
64	2E Mid Counties Development	2013	20,174						64
65	2E/3FI MSAL Mid Counties Per	2013	3,678						65
66	2E Milwaukee Millwork 1	2013	15,593						66
67	2E/3FI MSAL Norman Mechani	2013	1,500						67
68	2E/3FI MSAL Const. Contract R	2013	1,760						68
69	2E/3FI MSAL Petrow Contractin	2013	4,950						69
70	TOTAL (lines 4 thru 69)		\$ 16,641,787	\$		\$	\$	\$	70

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

Facility Name &amp; ID Number St Pauls House &amp; Hlth Cr Ctr

# 0005165

Report Period Beginning:

7/01/2014

Ending:

6/30/2015

**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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 16,641,787	\$		\$	\$	\$	1
2	2E Petrow Contracting 1	2013	12,215						2
3	3FI MSAL Carpeting for Reloca	2013	1,174						3
4	MIF Loan Interest May	2013	18,527						4
5	2E HVAC Fan Coils California	2013	15,385						5
6	2E Room Signs	2013	289						6
7	3FL MSAL Internal Moves from	2013	3,509						7
8	2E Room Signs 2	2013	815						8
9	2E Wiring 1	2013	182						9
10	2E Beauty Shop Fixtures 2	2013	60						10
11	2E 3FL Architectural Drawings	2013	5,660						11
12	2E 3FL Architectural Drawings	2013	31						12
13	2E 3FL Architectural Drawings	2013	1,063						13
14	2E 3FL Wiring - Racks	2013	643						14
15	2E Call Lights	2013	11,112						15
16	2E 3FL Cabling 25%	2013	46,000						16
17	2E 3FL Coax - 50%	2013	17,425						17
18	MIF Loan Interest June	2013	19,188						18
19	2E Electrical Hardware	2013	976						19
20	2E Electrical Hardware 2	2013	44						20
21	2E Henkel Electric 2	2013	20,000						21
22	2E Mid Counties Development	2013	21,800						22
23	2E Milwaukee Millwork 2	2013	780						23
24	2E Norman Mechanical 2	2013	13,164						24
25	2E Petrow Contracting 2	2013	20,625						25
26	MIF Loan Interest July	2013	19,122						26
27	2E HVAC 2	2013	1,050						27
28	2E HVAC 3	2013	6,195						28
29	2E Architectural Drawings 4	2013	84						29
30	2E Architectural Drawings 5	2013	122						30
31	2E/ 3FL Architectural Drawings	2013	3,698						31
32	2E Norman Mechanical 3	2013	14,400						32
33	2E Artwork and Decorations 2	2013	3,360						33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 16,920,485	\$		\$	\$	\$	34

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

Facility Name &amp; ID Number St Pauls House &amp; Hlth Cr Ctr

# 0005165

Report Period Beginning:

7/01/2014

Ending:

6/30/2015

**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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12B, Carried Forward</b>		\$ 16,920,485	\$		\$	\$	\$	1
2	2E TV Mount	2013	65						2
3	2E Dome Lights	2013	1,953						3
4	1 - 2 AL Nurse Call	2014	2,860						4
5	1 - 2 AL Nurse Call	2014	11,100						5
6	1 - 2 AL Nurse Call	2014	7,200						6
7	1 - 2 AL Nurse Call	2014	19,588						7
8	2E 3FL Closing Costs on Finan	2014	5,717						8
9	2E TV Brackets	2014	105						9
10	MIF Loan Interest August	2014	20,396						10
11	2E Paint and Primer	2014	773						11
12	2E 3FL Wireless 50% Hardwar	2014	56,510						12
13	MIF Loan Interest September	2014	20,258						13
14	2E Carpeting	2014	51,701						14
15	2E Bathroom Flooring	2014	10,560						15
16	2E Beauty Shop Flooring	2014	1,490						16
17	2E Medicine Cabinets	2014	1,142						17
18	2E Medicine Cabinets 2	2014	1,650						18
19	2E Beauty Shop Electrical	2014	5,760						19
20	2E Henkel Electric 3	2014	15,000						20
21	2E Mid Counties Development	2014	19,800						21
22	2E Milwaukee Millwork 3	2014	299						22
23	2E Norman Mechanical 4	2014	8,053						23
24	2E Petrow Contracting 3	2014	9,735						24
25	2E Petrow Contracting 4	2014	23,781						25
26	3FL Carpeting	2014	23,606						26
27	2E Carpeting 2	2014	24,426						27
28	3FL Tinaglia Architects	2014	2,620						28
29	3FL Elevator 50%	2014	33,637						29
30	3FL Tinaglia Architects 2	2014	115						30
31	2E 3FL Wireless Equipment	2014	18,020						31
32	2E 3FL Wireless Labor 50%	2014	19,246						32
33	2E 3FL Coax - 50% - 2	2014	17,425						33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 17,355,075	\$		\$	\$	\$	34

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

Facility Name &amp; ID Number St Pauls House &amp; Hlth Cr Ctr

# 0005165

Report Period Beginning:

7/01/2014

Ending:

6/30/2015

**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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12C, Carried Forward</b>		\$ 17,355,075	\$		\$	\$	\$	1
2	2E Medicine Cabinets	2014	450						2
3	2E HVAC Beauty Shop, Phase	2014	2,845						3
4	2E 3FL Closing Costs, Attorney	2014	13,055						4
5	2E 3FL IT UPS and Rack	2014	6,422						5
6	MIF Loan Interest October	2014	21,284						6
7	3FL Fire Alarm System	2014	320						7
8	2E Fan Coil Repair	2014	9,495						8
9	2E Spa Tiles	2014	30						9
10	3FL Henkel Electric	2014	10,000						10
11	3FL JS Goray Tuckpointing	2014	31,845						11
12	3FL Mid Counties Supervision	2014	4,550						12
13	2E 3FL Mid Counties Supervisi	2014	15,500						13
14	3FL One Source Roofing	2014	14,455						14
15	3FL Petrow Contracting - Demo	2014	31,625						15
16	MIF Loan Interest November	2014	21,794						16
17	3FL Netrix AP Licenses	2014	2,101						17
18	3FL Insulation IMICO	2014	7,367						18
19	3FL Healthsense Stage #1	2014	9,720						19
20	3FL Waste Management - Disp	2014	1,140						20
21	3FL Waste Management - Disp	2014	1,874						21
22	3FL Avaya Phone Switches	2014	4,200						22
23	3FL Insulation	2014	12,000						23
24	3FL Asbestos Fees	2014	950						24
25	3FL Waste Removal	2014	1,598						25
26	3FL Drywall	2014	963						26
27	3FL Drywall 2	2014	172						27
28	3FL Drywall 3	2014	2,218						28
29	3FL Drywall 4	2014	2,348						29
30	2E 3FL Henkel Electric 5	2014	40,000						30
31	3FL JS Goray Facade Repairs	2014	30,425						31
32	3FL JS Goray Facade Repairs	2014	37,446						32
33	2E 3FL Cabinets	2014	9,362						33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 17,702,629	\$		\$	\$	\$	34

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

Facility Name &amp; ID Number St Pauls House &amp; Hlth Cr Ctr

# 0005165

Report Period Beginning:

7/01/2014

Ending:

6/30/2015

**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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12D, Carried Forward</b>		\$ 17,702,629	\$		\$	\$	\$	1
2	2E 3FL Mid Counties 5	2014	14,107						2
3	2E 3FL Mid Counties Roof/Tuc	2014	9,397						3
4	3FL Milwaukee Millwork 5	2014	16,285						4
5	3FL Milwaukee Millwork 6	2014	798						5
6	3FL Milwaukee Millwork 7	2014	21,978						6
7	2E 3FL Hair Salon	2014	3,013						7
8	2E 3FL Norman Mechanical 5	2014	14,577						8
9	3FL One Source Roofing 2	2014	18,731						9
10	2E 3FL Petrow Contracting 5	2014	21,435						10
11	2E 3FL Petrow Contracting 6	2014	5,925						11
12	2E 3FL Blinds/Valance	2014	8,386						12
13	2E 3FL HVAC Service Group 1	2014	4,497						13
14	2E Spa Tub	2014	20,630						14
15	2E 3FL Itatica Patch Cords	2014	895						15
16	2E 3FL Itatica 25% Contract	2014	41,400						16
17	3FL Sheet Vinyl 1	2014	10,884						17
18	3FL Sheet Vinyl 2	2014	10,884						18
19	2E 3FL Paint	2014	516						19
20	2E 3FL Paint	2014	1,205						20
21	3FL Wall Mount LED Lights	2014	672						21
22	3FL Architect Consult	2014	373						22
23	2E 3FL Waste Disposal	2014	556						23
24	3FL Wanderguard	2014	7,035						24
25	3FL Wanderguard 2	2014	14,069						25
26	MIF Loan Interest December	2014	22,172						26
27	3FL Flooring Sheet Vinyl	2014	1,490						27
28	3FL Access Points - Nurse Cal	2014	8,055						28
29	3FL Drapes	2014	2,645						29
30	3FL TSG	2014	975						30
31	3FL Decorations	2014	872						31
32	3FL Healthsense - Nurse Call	2014	22,955						32
33	2 West Chiller	2014	125,847						33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 18,135,888	\$		\$	\$	\$	34

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

Facility Name &amp; ID Number St Pauls House &amp; Hlth Cr Ctr

# 0005165

Report Period Beginning:

7/01/2014

Ending:

6/30/2015

**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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12E, Carried Forward</b>		\$ 18,135,888	\$		\$	\$	\$	1
2	3FL Italia	2014	4,600						2
3	3FL Carpeting - Rooms & Corri	2014	23,606						3
4	3FL Kitchen Elevator - 2	2014	33,637						4
5	3FL Drywall - Ceiling Tiles	2014	14,218						5
6	2E 3FL Henkel Electric	2014	20,000						6
7	3FL Interstate Asbestos Remov	2014	20,570						7
8	3FL Cabinets	2014	5,659						8
9	2E Mid Counties Professional S	2014	11,668						9
10	3FL Custom Doors	2014	2,316						10
11	3FL Door Keypads	2014	562						11
12	2E 3FL Norman Mechanical	2014	10,000						12
13	2E 3FL Petrow Contracting	2014	37,280						13
14	3FL Pipe Insulation	2014	4,800						14
15	3FL Imico - Pipe Insulation	2014	11,383						15
16	3FL Mid Counties - Moisture Pa	2014	1,618						16
17	3FL Painting	2014	338						17
18	MIF Loan Interest January	2014	24,638						18
19	2E 3FL HVAC	2014	1,115						19
20	2E 3FL Electrical IT Closet	2014	3,500						20
21	2E 3FL Roller Shades	2014	645						21
22	2E 3FL Additional Wireless APs	2014	3,500						22
23	3FL Fire Alarm Set Up	2014	771						23
24	2E 3FL Sprinklers	2014	791						24
25	2E 3FL Sprinklers	2014	4,192						25
26	3FL Painting	2014	227						26
27	3FL Painting	2014	191						27
28	2E 3FI Painting	2014	534						28
29	2E 3FL Painting	2014	405						29
30	3FL Wanderguard	2014	240						30
31	2E 3FL Waste Removal	2014	1,005						31
32	ECX satin Aluminim Flag Pole	2008	2,187						32
33	Entrance Sign in front of buildin	2008	3,370						33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 18,385,453	\$		\$	\$	\$	34

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

Facility Name &amp; ID Number St Pauls House &amp; Hlth Cr Ctr

# 0005165

Report Period Beginning:

7/01/2014

Ending:

6/30/2015

**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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12F, Carried Forward</b>		\$ 18,385,453	\$		\$	\$	\$	1
2	3FL Architect Visit IDPH	2014	689						2
3	2E HVAC	2014	1,226						3
4	2E 3FL Supplies	2014	427						4
5	MIF Loan Interest February	2014	25,428						5
6	3FL Sprinklers	2014	1,170						6
7	3FL Wall Plates	2014	150						7
8	3FL Drywall	2014	2,104						8
9	3FL Henkel Electric Final	2014	35,750						9
10	3FL Mid Counties Final	2014	100						10
11	3FL Norman Mechanical Final	2014	48,020						11
12	2E 3FL Petrow Final	2014	64,570						12
13	2E Fire Alarms - Spa	2014	690						13
14	3FL Paint and Supplies	2014	1,256						14
15	3FL Window Fastners	2014	7						15
16	3FL Wanderguard	2014	2,590						16
17	3FL Elevator	2014	3,764						17
18	MIF Loan Interest March	2014	23,112						18
19	3FL Waste Management	2014	55						19
20	3FL Valances and Blinds	2014	2,256						20
21	3FL HVAC	2014	856						21
22	3FL Norman Mechanical	2014	1,449						22
23	2E Fire Alarms	2014	2,669						23
24	2E Spa Sprinklers	2014	4,026						24
25	3FL IT Cabinet	2014	10,000						25
26	3FL Signage	2014	310						26
27	3FL Signage	2014	141						27
28	3FL Signage	2014	158						28
29	3FL Healthsense	2014	3,000						29
30	3FL Elevator	2014	699						30
31	2E 3FL Final Architectural Visit	2014	1,170						31
32	2E 3FL Door Locks	2014	569						32
33	2E 3FL Door Closers	2014	285						33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 18,624,151	\$		\$	\$	\$	34

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$ 18,624,151	\$		\$	\$	\$	1
2	2E Smoke Detectors	2014	1,895						2
3	2E Carpet Finishing	2014	589						3
4	1 - 2 AL Nurse Call	2014	1,750						4
5	1 - 2 AL Nurse Call	2014	3,413						5
6	2 East Exhaust Fan for Spa	2014	4,248						6
7	Railings in Loading Dock	2015	1,895						7
8	Safety Glass for Door	2015	921						8
9	2E Bathroom Flooring	2015	10,560						9
10	Fire Door and Frame - 2 East	2015	9,250						10
11									11
12									12
13									13
14									14
15									15
16	Financial Statement Depreciation			660,551		660,551		12,443,073	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)		\$ 18,658,671	\$ 660,551		\$ 660,551	\$	\$ 12,443,073	34

\*\*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	\$ 2,520,872	\$ 120,582	\$ 120,582	\$	Var	\$ 1,864,905	71
72	Current Year Purchases	95,036	7,549	7,549		Var	7,549	72
73	Fully Depreciated Assets	1,283,886				Var	1,283,886	73
74								74
75	TOTALS	\$ 3,899,794	\$ 128,131	\$ 128,131	\$		\$ 3,156,340	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	Facility	Van	1994	\$ 37,650	\$	\$	\$		\$ 37,650	76
77	Facility	Bus	2007	15,000					15,000	77
78	Facility	Bus paint/repair	2007	7,796					7,796	78
79										79
80	TOTALS			\$ 60,446	\$	\$	\$		\$ 60,446	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)	\$ 22,721,992	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 788,682	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 788,682	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)	\$ 15,659,859	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	CIP Building	\$ 3,147	92
93	CIP Equipment	38,434	93
94			94
95		\$ 41,581	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 House & Hlth Cr Ctr

# 0005165

Report Period Beginning: 7/01/2014

Ending: 6/30/2015

**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	<b>TOTAL</b>				\$			7

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending                      Annual Rent

12. \_\_\_\_\_ /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: \$ 80,938 Description: Nursing Medical Equipment

(Attach a schedule detailing the breakdown of movable equipment)

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

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

\* 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 House & Hlth Cr Ctr # 0005165 Report Period Beginning: 7/01/2014 Ending: 6/30/2015  
**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? <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><u>St Pauls hires trained CNAs</u></p>	<p>2. <b>CLASSROOM PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <b>CLINICAL PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

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

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

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

	Service	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	39-3	hrs	\$	27,191	\$	417,156	\$	27,191	\$	417,156	1	
2	Licensed Speech and Language Development Therapist	39-3	hrs		13,299		234,164		13,299		234,164	2	
3	Licensed Recreational Therapist		hrs									3	
4	Licensed Physical Therapist	39-3	hrs		35,903		573,261		35,903		573,261	4	
5	Physician Care		visits									5	
6	Dental Care		visits									6	
7	Work Related Program		hrs									7	
8	Habilitation		hrs									8	
9	Pharmacy	39-2	# of prescripts					499,206			499,206	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10	
11	Academic Education		hrs									11	
12	Other (specify): <u>Lab &amp; X-ray</u>	39-3						63,918			63,918	12	
13	Other (specify):											13	
14	<b>TOTAL</b>			\$	76,393	\$	1,224,581	\$	563,124	76,393	\$	1,787,705	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 House & Hlth Cr Ctr**

# **0005165**

Report Period Beginning: **7/01/2014**

Ending:

**6/30//2015**

**XV. BALANCE SHEET - Unrestricted Operating Fund.**

As of **6/30//2015**

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 781,774	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 455,782 )	3,604,011		3
4	Supply Inventory (priced at cost )	36,714		4
5	Short-Term Investments	1,864,131		5
6	Prepaid Insurance	16,793		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	<b>\$ 6,303,423</b>	<b>\$</b>	<b>10</b>
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	103,081		13
14	Buildings, at Historical Cost	18,653,114		14
15	Leasehold Improvements, at Historical Cost	5,557		15
16	Equipment, at Historical Cost	3,960,240		16
17	Accumulated Depreciation (book methods)	(15,659,859)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	41,581		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 Attachment</u>	21,920		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	<b>\$ 7,125,634</b>	<b>\$</b>	<b>24</b>
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	<b>\$ 13,429,057</b>	<b>\$</b>	<b>25</b>

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 1,628,299	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	252,603		28
29	Short-Term Notes Payable	219,516		29
30	Accrued Salaries Payable	435,235		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	23,721		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>See Attached Schedule</u>	(2,123,955)		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	<b>\$ 435,419</b>	<b>\$</b>	<b>38</b>
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable	6,000,641		40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	<b>\$ 6,000,641</b>	<b>\$</b>	<b>45</b>
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	<b>\$ 6,436,060</b>	<b>\$</b>	<b>46</b>
47	<b>TOTAL EQUITY(page 18, line 24)</b>	<b>\$ 6,992,997</b>	<b>\$</b>	<b>47</b>
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	<b>\$ 13,429,057</b>	<b>\$</b>	<b>48</b>

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 6,838,223	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 6,838,223	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	154,775	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) <b>Rounding</b>	(1)	15
16	Other (describe)		16
17	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	<b>\$ 154,774</b>	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	<b>TOTAL Transfers (sum of lines 18-22)</b>	<b>\$</b>	23
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	<b>\$ 6,992,997</b>	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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 12,878,606	1
2	Discounts and Allowances for all Levels	(5,948,442)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 6,930,164</b>	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	5,638,792	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 5,638,792</b>	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	739	13
14	Non-Patient Meals	39,095	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	455,452	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	31,707	19
20	Radiology and X-Ray	29,705	20
21	Other Medical Services		21
22	Laundry	830	22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 557,528</b>	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	47,726	24
25	Interest and Other Investment Income***	8,181	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 55,907</b>	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a	<u>See Attachment</u>	397,377	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 397,377</b>	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 13,579,768</b>	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	2,263,743	31
32	Health Care	3,611,722	32
33	General Administration	2,926,459	33
<b>B. Capital Expense</b>			
34	Ownership	1,164,766	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	3,276,623	35
36	Provider Participation Fee	181,680	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 13,424,993</b>	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>154,775</b>	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ 154,775</b>	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,147,635	44
45	Private Pay - Net Inpatient Revenue	5,107,410	45
46	Medicare - Net Inpatient Revenue	675,119	46
47	Other-(specify)		47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	<b>\$ 6,930,164</b>	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 House & Hlth Cr Ctr**

# **0005165**

Report Period Beginning:

**7/01/2014**

Ending:

**6/30/2015**

**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	2,782	2,782	\$ 125,155	\$ 44.99	1
2	Assistant Director of Nursing					2
3	Registered Nurses	39,800	39,800	1,332,414	33.48	3
4	Licensed Practical Nurses	18,705	18,705	490,035	26.20	4
5	CNAs & Orderlies	101,872	101,872	1,394,043	13.68	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,952	1,952	37,604	19.26	8
9	Activity Director					9
10	Activity Assistants	8,175	8,175	166,010	20.31	10
11	Social Service Workers	5,843	5,843	147,966	25.32	11
12	Dietician	1,966	1,966	49,243	25.05	12
13	Food Service Supervisor	5,843	5,843	191,835	32.83	13
14	Head Cook	5,648	5,648	80,506	14.25	14
15	Cook Helpers/Assistants	33,492	33,492	351,820	10.50	15
16	Dishwashers					16
17	Maintenance Workers	11,948	11,948	258,964	21.67	17
18	Housekeepers	19,027	19,027	209,256	11.00	18
19	Laundry	5,913	5,913	63,621	10.76	19
20	Administrator	1,913	1,913	72,999	38.16	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	17,472	17,472	473,794	27.12	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,835	1,835	25,665	13.99	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,067	2,067	31,917	15.44	31
32	Other Health C: <u>AL/IL/Marketing</u>	10,219	10,219	227,269	22.24	32
33	Other(specify) <u>MDS Coordinator</u>	3,035	3,035	111,447	36.72	33
34	TOTAL (lines 1 - 33)	299,507	299,507	\$ 5,841,563 *	\$ 19.50	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	monthly	22,800	9-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	monthly	7,438	10-3	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	1,100	11-03	44
45	Social Service Consultant	146	5,579	12-03	45
46	Other(specify) <u>Chaplain</u>	monthly	10,355	11-03	46
47	<u>Senior Fit</u>	934	32,690	10-3	47
48					48
49	TOTAL (lines 35 - 48)	1,080	\$ 79,962		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	751	\$ 49,064	10-3	50
51	Licensed Practical Nurses	508	25,069	10-3	51
52	Certified Nurse Assistants/Aides	1,236	23,612	10-3	52
53	TOTAL (lines 50 - 52)	2,495	\$ 97,745		53



**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												
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8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name &amp; ID Number St Pauls House &amp; Hlth Cr Ctr

# 0005165

Report Period Beginning: 7/01/2014

Ending: 6/30/2015

## 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 \$10,915.92
- (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 Year
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 60,576 Line 10-2
- (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. \$ 181,680  
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. \$ N/A Has any meal income been offset against related costs? Yes Indicate the amount. \$ 39,095
- (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? 100%
- 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.