FOR BHF USE

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2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0005165

Facility Name: St Paul's House & Health Care Center

Address: 3800 North California Avenue (Number) Chicago (City) 60618 (Zip Code)

County: Cook

Telephone Number: (773) 478-4222 **Fax #** (773) 478-4516

HFS ID Number:

Date of Initial License for Current Owners: 1/10/24

Type of Ownership:

x	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
x	Charitable Corp.		Individual		State
	Trust		Partnership		County
			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

IRS Exemption Code

In the event there are further questions about this report, please contact:
Name: Rob Schlicht **Telephone Number:** (414) 431-9335
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/09 to 06/30/10 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) (Date)
(Print Name and Title) Rob Schlicht, Manager
(Firm Name & Address) Wipfli LLP, 10000 Innovation Drive, Suite 250, Milwaukee WI 53226
(Telephone) (414) 431-9335 Fax # (414) 431-9303

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number St Paul's House & Health Care Center # 0005165 Report Period Beginning: 07/01/09 Ending: 06/30/10

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	110	Skilled (SNF)	110	40,150	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	68	Sheltered Care (SC)	68	24,820	5
6		ICF/DD 16 or Less			6
7	178	TOTALS	178	64,970	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	10,243	8,769	7,301	26,313	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC		12,118		12,118	12
13	DD 16 OR LESS					13
14	TOTALS	10,243	20,887	7,301	38,431	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 59.15%

D. How many bed-hold days during this year were paid by the Department?
1,533 (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 [x]

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

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 [x]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 110 and days of care provided 7,301

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

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

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

Facility Name & ID Number St Paul's House & Health Care Center # 0005165 Report Period Beginning: 07/01/09 Ending: 06/30/10

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	458,050	36,851	2,251	497,152		497,152		497,152			1
2	Food Purchase		297,756		297,756		297,756		297,756			2
3	Housekeeping	168,849	40,630		209,479		209,479		209,479			3
4	Laundry	60,414	7,310	8,276	76,000		76,000	(1,300)	74,700			4
5	Heat and Other Utilities			278,466	278,466		278,466		278,466			5
6	Maintenance	154,883	35,235	178,771	368,889		368,889	(9,122)	359,767			6
7	Other (specify):*											7
8	**TOTAL General Services**	842,196	417,782	467,764	1,727,742		1,727,742	(10,422)	1,717,320			8
	B. Health Care and Programs											
9	Medical Director			13,660	13,660		13,660		13,660			9
10	Nursing and Medical Records	2,296,818	77	87,481	2,384,376		2,384,376	(14,857)	2,369,519			10
10a	Therapy											10a
11	Activities	159,098	1,963	25,501	186,562		186,562		186,562			11
12	Social Services	48,902		2,829	51,731		51,731		51,731			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,504,818	2,040	129,471	2,636,329		2,636,329	(14,857)	2,621,472			16
	C. General Administration											
17	Administrative	104,979		99,996	204,975		204,975		204,975			17
18	Directors Fees											18
19	Professional Services			29,030	29,030		29,030	(2,898)	26,132			19
20	Dues, Fees, Subscriptions & Promotions			35,147	35,147		35,147	(10,672)	24,475			20
21	Clerical & General Office Expenses	436,200	16,658	395,204	848,062		848,062	(291,653)	556,409			21
22	Employee Benefits & Payroll Taxes			883,681	883,681		883,681		883,681			22
23	Inservice Training & Education											23
24	Travel and Seminar			5,973	5,973		5,973		5,973			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			88,167	88,167		88,167		88,167			26
27	Other (specify):*											27
28	**TOTAL General Administration**	541,179	16,658	1,537,198	2,095,035		2,095,035	(305,223)	1,789,812			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,888,193	436,480	2,134,433	6,459,106		6,459,106	(330,502)	6,128,604			29

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

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

Facility Name & ID Number St Paul's House & Health Care Center #0005165 Report Period Beginning: 07/01/09 Ending: 06/30/10

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			627,970	627,970		627,970	(98,566)	529,404			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			97,841	97,841		97,841	(42,490)	55,351			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			23,123	23,123		23,123		23,123			35
36	Other (specify):*			13,002	13,002		13,002	(13,002)				36
37	**TOTAL Ownership**			761,936	761,936		761,936	(154,058)	607,878			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		446,642	857,992	1,304,634		1,304,634		1,304,634			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			60,225	60,225		60,225		60,225			42
43	Other (specify):*	214,908	9,457	4,078	228,443		228,443	(228,443)				43
44	**TOTAL Special Cost Centers**	214,908	456,099	922,295	1,593,302		1,593,302	(228,443)	1,364,859			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,103,101	892,579	3,818,664	8,814,344		8,814,344	(713,003)	8,101,341			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 Paul's House & Health Care Center # 0005165 Report Period Beginning: 07/01/09 Ending: 06/30/10

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(98,566)	30		9
10	Interest and Other Investment Income	(42,490)	32		10
11	Discounts, Allowances, Rebates & Refunds	(29,348)	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	(10,604)	21		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(10,672)	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	(521,323)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (713,003)		$	30

BHF USE ONLY								
48		49		50		51		52	

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

		1 Amount	2 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
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (713,003)		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 Yes	2 No	3 Amount	4 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

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St Paul's House & Health Care Center

ID# **0005165**

Report Period Beginning: **07/01/09**

Ending: **06/30/10**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Miscellaneous Income	$ (3,416)	21	1
2	Miscellaneous income nursing	(14,857)	10	2
3	LOC commission	(51,417)	21	3
4	Assisted living & St Paul Foundation salaries	(214,908)	43	4
5	Assisted living & SPF supplies	(9,457)	43	5
6	Assisted living & SPF other	(4,078)	43	6
7	Other revenue	(11,599)	21	7
8	Laundry revenue	(1,300)	4	8
9	Amort of Deferred finance costs - interest exp	(13,002)	36	9
10	Non allowable legal fees	(2,898)	19	10
11	Marketing promotions	(1,339)	21	11
12	Marketing Salaries	(82,777)	21	12
13	Capitalized repairs and maintenance	(9,122)	6	13
14	Bad debt expense	(101,153)	21	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**	(521,323)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number St Paul's House & Health Care Center # 0005165 **Report Period Beginning:** 07/01/09 **Ending:** 06/30/10

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(1,300)	0	0	0	0	0	0	0	0	0	0	(1,300)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(9,122)	0	0	0	0	0	0	0	0	0	0	(9,122)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(10,422)	0	0	0	0	0	0	0	0	0	0	(10,422)	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	(14,857)	0	0	0	0	0	0	0	0	0	0	(14,857)	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**	(14,857)	0	0	0	0	0	0	0	0	0	0	(14,857)	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	(2,898)	0	0	0	0	0	0	0	0	0	0	(2,898)	19
20	Fees, Subscriptions & Promotions	(10,672)	0	0	0	0	0	0	0	0	0	0	(10,672)	20
21	Clerical & General Office Expenses	(291,653)	0	0	0	0	0	0	0	0	0	0	(291,653)	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**	(305,223)	0	0	0	0	0	0	0	0	0	0	(305,223)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(330,502)	0	0	0	0	0	0	0	0	0	0	(330,502)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number St Paul's House & Health Care Center # 0005165 **Report Period Beginning:** 07/01/09 **Ending:** 06/30/10

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

	Capital Expense D. Ownership	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)	
30	Depreciation	(98,566)	0	0	0	0	0	0	0	0	0	0	(98,566)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(42,490)	0	0	0	0	0	0	0	0	0	0	(42,490)	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):*	(13,002)	0	0	0	0	0	0	0	0	0	0	(13,002)	36
37	**TOTAL Ownership**	(154,058)	0	0	0	0	0	0	0	0	0	0	(154,058)	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):*	(228,443)	0	0	0	0	0	0	0	0	0	0	(228,443)	43
44	**TOTAL Special Cost Centers**	(228,443)	0	0	0	0	0	0	0	0	0	0	(228,443)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(713,003)	0	0	0	0	0	0	0	0	0	0	(713,003)	45

Facility Name & ID Number St Paul's House & Health Care Center # 0005165 Report Period Beginning: 07/01/09 Ending: 06/30/10

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
n/a		See attached		See attached		

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	Administrative Expenses	$ 99,996	Lutheran Life Communities	100.00%	$ 99,996	$	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			$ 99,996			$ 99,996	$ *	14

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

Facility Name & ID Number St Paul's House & Health Care Center # 0005165 Report Period Beginning: 07/01/09 Ending: 06/30/10

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Roger Paulsberg	Chairman	Administrative	0.00	376,442	4	10.00	Alloc Salary	$ 37,644	17-3	1
2	Carl Moellenkamp	Vice President	Administrative	0.00	241,726	2	5.00	Alloc Salary	12,086	17-3	2
3	Jim Holbrook	Treasurer	Administrative	0.00	238,942	4	10.00	Alloc Salary	23,894	17-3	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 73,624		13

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

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

Facility Name & ID Number St Paul's House & Health Care Center # 0005165 Report Period Beginning: 07/01/09 Ending: 06/30/10

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 [x] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Administrative	Direct allocation			$	$		$ 99,996	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					$	$		$ 99,996	25

Facility Name & ID Number St Paul's House & Health Care Center # 0005165 Report Period Beginning: 07/01/09 Ending: 06/30/10

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	1995 revenue bonds		x	Financing	none	06/96	$ 6,500,000	$ 4,525,000	2/1/25	3.9600	$ 55,272	1
2	Lutheran Life Communities	x		Bed Capital Leaase						0.1584	3,907	2
3												3
4												4
5												5
	Working Capital											
6	LaSalle Bank		x	Line of Credit				1,217,833			38,662	6
7												7
8												8
9	TOTAL Facility Related						$ 6,500,000	$ 5,742,833			$ 97,841	9
	B. Non-Facility Related*											
10	Interest Income										(42,490)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (42,490)	14
15	TOTALS (line 9+line14)						$ 6,500,000	$ 5,742,833			$ 55,351	15

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

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

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

Facility Name & ID Number St Paul's House & Health Care Center # 0005165 **Report Period Beginning:** 07/01/09 **Ending:** 06/30/10

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost 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 2010 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:		
	2005	8
	2006	9
	2007	10
	2008	11
	2009	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2009	$	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.

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME St Paul's House & Health Care Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0005165

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 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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

Facility Name & ID Number St Paul's House & Health Care Center # 0005165 Report Period Beginning: 07/01/09 Ending: 06/30/10

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? [x] (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? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [x] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

St. Paul's Residence, 2815 W. Baron, Chicago IL 60618

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1910	$ 103,080	1
2					2
3	TOTALS			$ 103,080	3

Facility Name & ID Number St Paul's House & Health Care Center # 0005165 Report Period Beginning: 07/01/09 Ending: 06/30/10

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4				1986	$ 3,871,467	$	20	$	$	$ 3,871,467	4
5				1974	1,284,322		30	42,811	42,811	1,140,282	5
6				1949	332,671					332,671	6
7				1980	3,941					3,941	7
8											8
	Improvement Type**										
9	Various			1976	27,003		20			27,003	9
10	Various			1978	751,898		20			751,898	10
11	Various			1981	74,417		20			74,417	11
12	Various			1982	88,065		20			88,065	12
13	Various			1984	21,915		20			21,915	13
14	Various			1985	235,600		20	902	902	227,492	14
15	Various			1986	99,966		20	914	914	91,735	15
16	Various			1987	17,045		20	492	492		16
17	Various			1988	1,500		20			1,500	17
18	Various			1989	5,140		20			5,140	18
19	Various			1990	58,255		20	1,461	1,461	58,255	19
20	Various			1991	7,167		20	425	425	6,072	20
21	Various			1992	48,661		20	2,366	2,366	28,151	21
22	Various			1994	15,410		20	465	465	13,552	22
23	Various			1995	8,236		20	413	413	6,167	23
24	Various			1996	244,921		20	12,247	12,247	127,455	24
25	Various			1997	5,967,238		20	200,717	200,717	2,758,524	25
26	Various			1998	95,528		20	3,416	3,416	66,670	26
27	Various			1999	148,127		20	6,634	6,634	87,238	27
28	Various			2000	89,166		20	4,458	4,458	44,997	28
29	Various			2001	1,596,476		20	80,521	80,521	743,911	29
30	Various			2002	37,453		20	2,846	2,846	22,905	30
31	Various			2003	105,885		20	7,690	7,690	76,787	31
32	Various			2004	53,627		20	6,700	6,700	42,235	32
33	Various			2005	42,331		20	2,464	2,464	13,028	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 Paul's House & Health Care Center # 0005165 Report Period Beginning: 07/01/09 Ending: 06/30/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
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	Financial Statement Depreciation			627,970			(627,970)		69
70	TOTAL (lines 4 thru 69)		$ 15,333,431	$ 627,970		$ 377,942	$ (250,028)	$ 10,733,473	70

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

Facility Name & ID Number St Paul's House & Health Care Center # 0005165 Report Period Beginning: 07/01/09 Ending: 06/30/10

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 15,333,431	$ 627,970		$ 377,942	$ (250,028)	$ 10,733,473	1
2	Hvac - New compressor	2006	15,807		20	790	790	3,160	2
3	Hvac - Thermostat, Gas valve, knobs	2006	639		20	32	32	128	3
4	Hvac, low Water cutoff	2006	1,149		20	57	57	229	4
5	Hvac - new coplematic compressor	2006	22,726		20	1,136	1,136	4,545	5
6	Replace pump housing	2007	1,908		20	95	95	381	6
7	Valve plates for chiller	2007	1,592		20	80	80	319	7
8	Painting of chapel	2007	16,159		20	808	808	2,424	8
9	Painting of auditorium	2007	7,785		20	389	389	1,168	9
10	Fire panel replacement	2007	10,314		20	516	516	1,547	10
11	Auditorium Carpentry and drywall	2007	10,170		20	509	509	1,526	11
12	Roof repairs	2007	25,000		20	1,250	1,250	3,750	12
13	Elevator - new piping	2007	8,212		20	411	411	1,232	13
14	Elevator - replace hatch door	2007	3,811		20	191	191	572	14
15	Carpet in auditorium	2007	43,875		20	2,194	2,194	6,582	15
16	Restoration of auditorium	2007	45,018		20	2,251	2,251	6,753	16
17	Server room wire closet	2007	31,906		20	1,595	1,595	4,786	17
18	Booster heater	2007	5,900		20	295	295	885	18
19	Fire alarm equipment	2007	4,925		20	246	246	739	19
20	Guage thermometers and plumbing	2007	4,770		20	239	239	716	20
21	Landscaping work	2007	10,690		20	535	535	1,604	21
22	Plumbing work	2007	2,866		20	143	143	430	22
23	Air compressors and fans	2007	2,966		20	148	148	445	23
24	Backwater valves	2007	5,240		20	262	262	786	24
25	Generator annunciators	2007	4,065		20	203	203	610	25
26	Loading dock stairs	2007	4,700		20	235	235	705	26
27	Phone conduits	2007	2,860		20	143	143	429	27
28	Chilled water pump	2008	8,985		20	449	449	1,348	28
29	Compressor	2008	9,485		20	474	474	1,423	29
30	New drywall - boiler room	2008	7,120		20	356	356	1,068	30
31	Holby tempering valve	2008	25,510		20	1,276	1,276	3,827	31
32	Boiler tubes & installation	2008	4,843		20	242	242	726	32
33	Carpet	2008	1,665		20	83	83	500	33
34	TOTAL (lines 1 thru 33)		$ 15,686,092	$ 627,970		$ 395,575	$ (232,395)	$ 10,788,816	34

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

Facility Name & ID Number St Paul's House & Health Care Center # 0005165 Report Period Beginning: 07/01/09 Ending: 06/30/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 15,686,092	$ 627,970		$ 395,575	$ (232,395)	$ 10,788,816	1
2	Carpet installation	2008	1,212		20	61	61	182	2
3	Aluminum Flag pole	2008	2,187		20	109	109	328	3
4	Entrance sign	2008	3,370		20	169	169	506	4
5	Plumbing and concrete	2008	5,428		20	271	271	814	5
6	Generator and actuator	2008	4,889		20	244	244	489+244	6
7	Wiring and circuitry	2008	3,186		20	159	159	478	7
8	Radiator and hose/cables	2008	3,045		20	152	152	457	8
9	Railing and concrete north ada	2008	3,204		20	160	160	480	9
10	Roof repairs	2008	1,985		20	99	99	198	10
11	Painting of 2 East corridors	2008	3,475		20	174	174	348	11
12	Roof repairs	2008	1,175		20	59	59	118	12
13	Roof repairs	2008	417		20	21	21	42	13
14	Roof repairs	2008	833		20	42	42	84	14
15	Tucking pointing outside accounting office	2008	1,000		20	50	50	100	15
16	Tucking pointing outside accounting office	2008	2,000		20	100	100	200	16
17	New blower motors for 2w dining room heaters	2008	3,535		20	177	177	354	17
18	Roof repairs	2008	2,500		20	125	125	250	18
19	Painting of 2 East corridors	2008	2,750		20	138	138	276	19
20	Painting of resident rooms #202 & 215	2008	1,367		20	68	68	136	20
21	Painting of resident rooms #370	2008	406		20	20	20	40	21
22	Hot water recirculation pump	2008	896		20	45	45	90	22
23	Hot water recirculation pump	2008	1,664		20	83	83	166	23
24	Painting of resident rooms 219, 221 & 222	2008	2,257		20	113	113	226	24
25	Painting of 2 East corridors	2008	2,750		20	138	138	276	25
26	Painting of resident rooms 220, 224, nurses lounge and conf	2008	3,130		20	157	157	314	26
27	Painting of 2 east nurses station and common areas	2008	2,378		20	119	119	238	27
28	Painting of 2 west nursing station and half of corridor	2008	2,062		20	103	103	206	28
29	Roof and tuckpointing	2008	5,147		20	257	257	514	29
30	Intereior and exterior painting	2008	2,655		20	133	133	266	30
31	Painting of 2 west corridor	2009	1,612		20	81	81	162	31
32	New phone system invoice 1 of 3	2009	3,381		20	169	169	338	32
33	New phone system invoice 2 of 3	2009	6,366		20	318	318	636	33
34	TOTAL (lines 1 thru 33)		$ 15,768,354	$ 627,970		$ 399,688	$ (228,282)	$ 10,797,639	34

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

Facility Name & ID Number St Paul's House & Health Care Center # 0005165 Report Period Beginning: 07/01/09 Ending: 06/30/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 15,768,354	$ 627,970		$ 399,688	$ (228,282)	$ 10,797,639	1
2	East renovation plan review	2009	4,226		20	211	211	211	2
3	East renovation loan acquisition fee	2009	5,500		20	275	275	275	3
4	East renovation signage	2009	329		20	16	16	16	4
5	East renovation carpet install 1st payment	2009	29,697		20	1,485	1,485	1,485	5
6	East renovation electrical work 1st payment	2009	25,340		20	1,267	1,267	1,267	6
7	East renovation mechanical work 1st payment	2009	19,800		20	990	990	990	7
8	East renovation construction services 1st payment	2009	45,492		20	2,275	2,275	2,275	8
9	East renovation floor covering spa room 1st payment	2009	5,728		20	286	286	286	9
10	East renovation SARA equipment installation 1st payment	2009	19,507		20	975	975	975	10
11	East renovation architecural drawings	2009	2,125		20	106	106	106	11
12	New carpeting in room 382	2009	1,380		20	69	69	69	12
13	Install upgrades for IDPH regulations	2009	3,495		20	175	175	175	13
14	East renovation construction loan fees	2009	8,310		20	416	416	416	14
15	Hard wired smoke detectors for basement	2009	1,725		20	86	86	86	15
16	Roof repairs	2009	750		20	38	38	38	16
17	Roof repairs	2009	1,500		20	75	75	75	17
18	Roof repairs	2009	1,250		20	63	63	63	18
19	Roof repairs	2009	1,500		20	75	75	75	19
20	East renovation sprinkler head addition	2009	779		20	39	39	39	20
21	East renovation electrical work 2nd payment	2009	25,340		20	1,267	1,267	1,267	21
22	East renovation network cable installation	2009	9,948		20	497	497	497	22
23	East renovation SARA equipment installation	2009	15,608		20	780	780	780	23
24	East renovation HVAC work	2009	27,859		20	1,393	1,393	1,393	24
25	East renovation electrical work 3rd payment	2009	25,340		20	1,267	1,267	1,267	25
26	East renovation 2nd payment mechanical work	2009	26,333		20	1,317	1,317	1,317	26
27	East renovation 2nd payment construction services	2009	105,342		20	5,267	5,267	5,267	27
28	Door access system	2009	4,424		20	221	221	221	28
29	Door access system	2009	4,424		20	221	221	221	29
30	Roof repairs	2009	4,670		20	234	234	234	30
31	East renovation hardware	2009	14		20	1	1	1	31
32	East renovation locks	2009	101		20	5	5	5	32
33	East renovation electrical work	2009	22,400		20	1,120	1,120	1,120	33
34	TOTAL (lines 1 thru 33)		$ 16,218,590	$ 627,970		$ 422,200	$ (205,770)	$ 10,820,151	34

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

Facility Name & ID Number St Paul's House & Health Care Center # 0005165 Report Period Beginning: 07/01/09 Ending: 06/30/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 16,218,590	$ 627,970		$ 422,200	$ (205,770)	$ 10,820,151	1
2	East renovation carpet install	2009	29,899		20	1,495	1,495	1,495	2
3	East renovation employee entrance flooring	2009	4,240		20	212	212	212	3
4	East renovation SPA room flooring	2009	5,728		20	286	286	286	4
5	East renovation SARA system	2009	3,092		20	155	155	155	5
6	East renovation construction documents	2009	1,080		20	54	54	54	6
7	East renovation smoke detector replacement	2009	948		20	47	47	47	7
8	East renovation call cords with pendant	2009	280		20	14	14	14	8
9	East renovation network cabling	2010	3,762		20	188	188	188	9
10	East renovation new building signage	2010	2,265		20	113	113	113	10
11	East renovation Permint expedition	2010	1,500		20	75	75	75	11
12	East renovation room signage	2010	67		20	3	3	3	12
13	East renovation blueprint copies	2010	38		20	2	2	2	13
14	Pipe repairs	2010	3,410		20	171	171	171	14
15	East renovation food trays	2010	1,508		20	75	75	75	15
16	East renovation china, flatware, domes and bases	2010	6,188		20	309	309	309	16
17	East renovation dining supplies	2010	313		20	16	16	16	17
18	Mixing valve replacement	2010	3,400		20	170	170	170	18
19	East renovation mechanical work final payment	2010	64,535		20	3,227	3,227	3,227	19
20	East renovation plans and drawings	2010	580		20	29	29	29	20
21	West ceiling tile replacement	2010	28,642		20	1,432	1,432	1,432	21
22	West ceiling tiles and lighting	2010	33,912		20	1,696	1,696	1,696	22
23	Fire alarm repairs	2010	4,079		20	204	204	204	23
24	HVAC repairs	2010	6,856		20	343	343	343	24
25	Refinish Floors	2010	21,153		20	1,058	1,058	1,058	25
26	Clean exterior windows	2010	4,400		20	220	220	220	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 16,450,465	$ 627,970		$ 433,794	$ (194,176)	$ 10,831,745	34

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

Facility Name & ID Number St Paul's House & Health Care Center # 0005165 Report Period Beginning: 07/01/09 Ending: 06/30/10

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,336,524	$	$ 57,735	$ 57,735	10	$ 1,120,897	71
72	Current Year Purchases	333,158		33,316	33,316	10	33,316	72
73	Fully Depreciated Assets	1,118,898				10	1,118,898	73
74								74
75	TOTALS	$ 2,788,580	$	$ 91,051	$ 91,051		$ 2,273,111	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	Van	1994	$ 37,650	$	$	$		$ 37,650	76
77	Facility	Bus	2007	15,000		3,000	3,000	5	12,000	77
78	Facility	Bus paint and repair	2007	7,796		1,559	1,559	5	4,677	78
79										79
80	TOTALS			$ 60,446	$	$ 4,559	$ 4,559		$ 54,327	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)	$ 19,402,571	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 627,970	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 529,404	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (98,566)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 13,159,182	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number St Paul's House & Health Care Center # 0005165 Report Period Beginning: 07/01/09 Ending: 06/30/10

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

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

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

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.	/2011	$
13.	/2012	$
14.	/2013	$

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: $ 23,123 Description: See attached schedule
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

* 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 Paul's House & Health Care Center # 0005165 Report Period Beginning: 07/01/09 Ending: 06/30/10

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [x] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		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	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.

Facility Name & ID Number St Paul's House & Health Care Center # 0005165 Report Period Beginning: 07/01/09 Ending: 06/30/10

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-03	hrs	$		$ 255,230	$		$ 255,230	1
2	Licensed Speech and Language Development Therapist	39-03	hrs			85,705			85,705	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-03	hrs			323,526			323,526	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-02	# of prescrpts				446,642		446,642	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See attached					24,467			24,467	13
14	TOTAL			$		$ 688,928	$ 446,642		$ 1,135,570	14

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

STATE OF ILLINOIS

Facility Name & ID Number St Paul's House & Health Care Center # 0005165 Report Period Beginning: 07/01/09 Ending: 06/30/10

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/10 (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	$ 161,195	$	1
2	Cash-Patient Deposits	41,209		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,759,268		3
4	Supply Inventory (priced at)	47,933		4
5	Short-Term Investments	2,438,037		5
6	Prepaid Insurance	28,475		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 5,476,117	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	108,638		13
14	Buildings, at Historical Cost	16,033,750		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	3,309,225		16
17	Accumulated Depreciation (book methods)	(12,308,627)		17
18	Deferred Charges	190,657		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See grouping schedule	21,391		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 7,355,034	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 12,831,151	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 903,295	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	229,440		28
29	Short-Term Notes Payable	356,000		29
30	Accrued Salaries Payable	447,607		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	6,882		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See grouping schedule	1,413,934		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,357,158	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	571,833		40
41	Bonds Payable	4,315,000		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 4,886,833	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 8,243,991	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 4,587,160	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 12,831,151	$	48

*(See instructions.)

Facility Name & ID Number St Paul's House & Health Care Center # 0005165 **Report Period Beginning:** 07/01/09 **Ending:** 06/30/10

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,993,155	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,993,155	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	594,005	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)**	$ 594,005	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)**	$ 4,587,160	24 *

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

Facility Name & ID Number St Paul's House & Health Care Center # 0005165 Report Period Beginning: 07/01/09 Ending: 06/30/10

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,623,752	1
2	Discounts and Allowances for all Levels	(1,825,097)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,798,655	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,522,299	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,522,299	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	32	12
13	Barber and Beauty Care	(48)	13
14	Non-Patient Meals	33,650	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	425,469	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	18,287	19
20	Radiology and X-Ray	6,345	20
21	Other Medical Services		21
22	Laundry	1,300	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 485,035	23
	D. Non-Operating Revenue		
24	Contributions	157,732	24
25	Interest and Other Investment Income***	42,490	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 200,222	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See grouping schedule	402,138	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 402,138	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,408,349	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,727,742	31
32	Health Care	2,636,329	32
33	General Administration	2,095,035	33
	B. Capital Expense		
34	Ownership	761,936	34
	C. Ancillary Expense		
35	Special Cost Centers	1,533,077	35
36	Provider Participation Fee	60,225	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,814,344	40
41	**Income before Income Taxes (line 30 minus line 40)****	594,005	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 594,005	43

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

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

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

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

Facility Name & ID Number St Paul's House & Health Care Center # 0005165 Report Period Beginning: 07/01/09 Ending: 06/30/10

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,856	2,110	$ 109,210	$ 51.76	1
2	Assistant Director of Nursing					2
3	Registered Nurses	30,791	36,025	1,189,973	33.03	3
4	Licensed Practical Nurses	12,788	14,834	282,389	19.04	4
5	CNAs & Orderlies	66,499	70,754	715,246	10.11	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,950	2,184	40,538	18.56	9
10	Activity Assistants	5,491	6,150	62,809	10.21	10
11	Social Service Workers	1,838	2,059	48,902	23.76	11
12	Dietician	1,958	2,193	38,090	17.37	12
13	Food Service Supervisor	3,960	4,435	104,938	23.66	13
14	Head Cook	5,826	6,525	72,430	11.10	14
15	Cook Helpers/Assistants	26,139	29,276	242,592	8.29	15
16	Dishwashers					16
17	Maintenance Workers	6,099	6,831	154,883	22.67	17
18	Housekeepers	21,045	23,570	168,849	7.16	18
19	Laundry	6,379	7,144	60,414	8.46	19
20	Administrator	1,950	2,184	104,979	48.07	20
21	Assistant Administrator					21
22	Other Administrative	1,950	2,184	82,777	37.90	22
23	Office Manager					23
24	Clerical	16,914	18,944	353,423	18.66	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: Chaplain	1,965	2,201	55,751	25.33	32
33	Other(specify) Assisted Living	13,955	15,629	214,908	13.75	33
34	TOTAL (lines 1 - 33)	229,353	255,232	$ 4,103,101 *	$ 16.08	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Hourly	$ 940	01-03	35
36	Medical Director	Monthly	13,660	09-03	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	Monthly	949	11-03	44
45	Social Service Consultant		2,658	12-03	45
46	Other(specify)				46
47	Chaplain	Hourly	8,320	11-03	47
48					48
49	TOTAL (lines 35 - 48)		$ 26,527		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	11,520	$ 341,022	10-03	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	8,422	97,867	10-03	52
53	TOTAL (lines 50 - 52)	19,942	$ 438,889		53

Facility Name & ID Number St Paul's House & Health Care Center # 0005165 Report Period Beginning: 07/01/09 Ending: 06/30/10

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Eliana Casella	Administrator	0	$ 104,979
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 104,979

B. Administrative - Other

Description	Amount
Lutheran Life Communities - Admin expenses	$ 99,996
TOTAL (agree to Schedule V, line 17, col. 3)	$ 99,996
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Frost Ruttenberg & Rothblatt	Accounting/Consulting	$ 10,200
Clifton Gunderson	Audit	7,457
Carlton Lorenz	Legal fees	225
Lock Lord Bissell	Legal fees	2,898
Continuum Development	Operational consulting	5,000
Elizabeth Walp	HR Consulting	323
Its Never 2 Late	IT Consulting	450
Duldulao, Fredmyar	Reimbursement consulting	1,000
William Blair	Investment consulting	1,477
Non allow legal		(2,898)
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 26,132

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 74,730
Unemployment Compensation Insurance	21,591
FICA Taxes	312,974
Employee Health Insurance	355,553
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Life insurance	42,423
Retirmement benefits	71,364
LT Disability	(1,312)
Drug screening	7,621
Dental Insurance	(1,263)
TOTAL (agree to Schedule V, line 22, col.8)	$ 883,681

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	2,015
Health Care Worker Background Check	3,040
(Indicate # of checks performed 304)	
Patient Background Checks	2,150
Advertising	10,822
Dues and subscriptions	17,120
Less: Public Relations Expense	( )
Non-allowable advertising	(10,672)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 24,475

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	5,973
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 5,973

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number St Paul's House & Health Care Center # 0005165 Report Period Beginning: 07/01/09 Ending: 06/30/10

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
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 Paul's House & Health Care Center # 0005165 Report Period Beginning: 07/01/09 Ending: 06/30/10

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. **$5509, Life Services Network**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **n/a**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **n/a**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **67,173** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **x** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **60,225**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(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. $ Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **33,650**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100% ln 1**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/a**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **n/a**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **KPMG**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **n/a**
Attach invoices and a summary of services for all architect and appraisal fees.