FOR BHF USE

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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.

2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

I. IDPH License ID Number: 0013920

Facility Name: ST PAULS HOME

Address: 1021 WEST E STREET (Number) BELLEVILLE (City) 62220 (Zip Code)

County: ST. CLAIR

Telephone Number: (618) 233-2095 **Fax #** (618) 233-2109

HFS ID Number:

Date of Initial License for Current Owners: UNABLE TO LOCATE

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: BKD, LLP **Telephone Number:** (314) 231-5544
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 01/01/2014 to 12/31/2014 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) KEVIN WELLEN, MANAGING DIRECTOR
(Firm Name & Address) BKD, LLP, 201 N. BROADWAY, STE 6060, ST. LOUIS, MO 63102
(Telephone) (314) 231-5544 Fax # (314)231-9731

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 PAULS HOME # 0013920 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	78	Skilled (SNF)	78	28,470	1
2		Skilled Pediatric (SNF/PED)			2
3	35	Intermediate (ICF)	35	12,775	3
4		Intermediate/DD			4
5	62	Sheltered Care (SC)	40	14,600	5
6		ICF/DD 16 or Less			6
7	175	TOTALS	153	55,845	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	10,670	10,365	2,568	23,603	8
9	SNF/PED					9
10	ICF	8,366	2,150		10,516	10
11	ICF/DD					11
12	SC		5,033		5,033	12
13	DD 16 OR LESS					13
14	TOTALS	19,036	17,548	2,568	39,152	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 70.11%

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

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
OUTPATIENT THERAPY SVCS TO APARTMENT ILU, SC RESIDENTS

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [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 1926

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 78 and days of care provided 2,568

Medicare Intermediary NATIONAL GOVERNMENT SERVICES, INC.

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

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

Tax Year: 01/01/2014 Fiscal Year: 12/01/2014

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

Facility Name & ID Number ST PAULS HOME # 0013920 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	364,692	26,431	12,466	403,589		403,589	(7,264)	396,325			1
2	Food Purchase		286,408		286,408		286,408		286,408			2
3	Housekeeping	209,252	23,167	2,200	234,619		234,619		234,619			3
4	Laundry	101,934	10,866		112,800		112,800		112,800			4
5	Heat and Other Utilities			195,501	195,501		195,501		195,501			5
6	Maintenance	83,080	311	80,791	164,182		164,182		164,182			6
7	Other (specify):* Waste Removal			13,715	13,715		13,715		13,715			7
8	TOTAL General Services	758,958	347,183	304,673	1,410,814		1,410,814	(7,264)	1,403,550			8
	B. Health Care and Programs											
9	Medical Director			7,200	7,200		7,200		7,200			9
10	Nursing and Medical Records	2,088,394	36,605	47,489	2,172,488		2,172,488	(19,864)	2,152,624			10
10a	Therapy											10a
11	Activities	63,249	6,717		69,966		69,966		69,966			11
12	Social Services	34,419			34,419		34,419		34,419			12
13	CNA Training											13
14	Program Transportation	22,222		3,465	25,687		25,687		25,687			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,208,284	43,322	58,154	2,309,760		2,309,760	(19,864)	2,289,896			16
	C. General Administration											
17	Administrative	14,730			14,730	105,465	120,195		120,195			17
18	Directors Fees											18
19	Professional Services			466,857	466,857		466,857		466,857			19
20	Dues, Fees, Subscriptions & Promotions			62,540	62,540		62,540	(36,492)	26,048			20
21	Clerical & General Office Expenses	318,138	21,593	52,206	391,937	(105,465)	286,472	(20,570)	265,902			21
22	Employee Benefits & Payroll Taxes			725,103	725,103		725,103		725,103			22
23	Inservice Training & Education											23
24	Travel and Seminar			9,366	9,366		9,366		9,366			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			73,853	73,853		73,853		73,853			26
27	Other (specify):* Pre construction exp			500	500		500		500			27
28	TOTAL General Administration	332,868	21,593	1,390,425	1,744,886		1,744,886	(57,062)	1,687,824			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,300,110	412,098	1,753,252	5,465,460		5,465,460	(84,190)	5,381,270			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 PAULS HOME #0013920 **Report Period Beginning:** 01/01/2014 **Ending:** 12/31/2014

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			327,415	327,415		327,415		327,415			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			111,131	111,131		111,131	(6,491)	104,640			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			6,872	6,872		6,872		6,872			35
36	Other (specify):*											36
37	**TOTAL Ownership**			445,418	445,418		445,418	(6,491)	438,927			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		134,627	468,212	602,839		602,839		602,839			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			267,919	267,919		267,919		267,919			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		134,627	736,131	870,758		870,758		870,758			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,300,110	546,725	2,934,801	6,781,636		6,781,636	(90,681)	6,690,955			45

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

Facility Name & ID Number ST PAULS HOME # 0013920 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	(7,264)	1		4
5	Telephone, TV & Radio in Resident Rooms	(13,940)	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	(6,491)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(5,195)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(36,492)	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	(21,299)	21		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (90,681)		$	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))**	$ (90,681)		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

ST PAULS HOME

ID# 0013920

Report Period Beginning: 01/01/2014

Ending: 12/31/2014

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	VENDING	$ (1,435)	21	1
2	OTHER INCOME	(19,864)	10	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				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**	(21,299)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number ST PAULS HOME # 0013920 **Report Period Beginning:** 01/01/2014 **Ending:** 12/31/2014

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	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	(7,264)	0	0	0	0	0	0	0	0	0	0	(7,264)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(7,264)	0	0	0	0	0	0	0	0	0	0	(7,264)	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	(19,864)	0	0	0	0	0	0	0	0	0	0	(19,864)	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**	(19,864)	0	0	0	0	0	0	0	0	0	0	(19,864)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(36,492)	0	0	0	0	0	0	0	0	0	0	(36,492)	20
21	Clerical & General Office Expenses	(20,570)	0	0	0	0	0	0	0	0	0	0	(20,570)	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**	(57,062)	0	0	0	0	0	0	0	0	0	0	(57,062)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(84,190)	0	0	0	0	0	0	0	0	0	0	(84,190)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number ST PAULS HOME **#** 0013920 **Report Period Beginning:** 01/01/2014 **Ending:** 12/31/2014

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	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	(6,491)	0	0	0	0	0	0	0	0	0	0	(6,491)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(6,491)	0	0	0	0	0	0	0	0	0	0	(6,491)	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):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(90,681)	0	0	0	0	0	0	0	0	0	0	(90,681)	45

Facility Name & ID Number ST PAULS HOME # 0013920 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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
N/A						

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				$			$	$	1
2	V									2
3	V									3
4	V									4
5	V									5
6	V									6
7	V									7
8	V									8
9	V									9
10	V									10
11	V									11
12	V									12
13	V									13
14	Total				$			$	$ *	14

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

Facility Name & ID Number ST PAULS HOME # 0013920 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number ST PAULS HOME # 0013920 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

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

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

Facility Name & ID Number ST PAULS HOME # 0013920 Report Period Beginning: 01/01/2014 Ending: 2/31/2014

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 [X]

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

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

	1 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						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number ST PAULS HOME # 0013920 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	FIRST BANK		X	NOTE PAYABLE TERM LOA	$120,059.82	12/10/13	$ 12,673,417	$ 12,673,417	12/10/2026	0.0500	$ 111,131	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$120,059.82		$ 12,673,417	$ 12,673,417			$ 111,131	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 12,673,417	$ 12,673,417			$ 111,131	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

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

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

Facility Name & ID Number ST PAULS HOME **#** 0013920 **Report Period Beginning:** 01/01/2014 **Ending:** 12/31/2014

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 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 2014 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:		
	2009	8
	2010	9
	2011	10
	2012	11
	2013	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2013	$	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.

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME ST PAULS HOME COUNTY ST. CLAIR

FACILITY IDPH LICENSE NUMBER 0013920

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2013 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 2013.

	(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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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

Facility Name & ID Number ST PAULS HOME # 0013920 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 52,096 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories _____

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. [ ] (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).

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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	RESIDENT USE	178,000	1926	$ 22,696	1
2					2
3	TOTALS	178,000		$ 22,696	3

Facility Name & ID Number ST PAULS HOME # 0013920 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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			1955	1955	$ 166,556	$	25	$	$	$ 166,556	4
5			1957	1957	148,250		50			148,250	5
6			1962	1962	266,677		50			266,677	6
7			1971	1971	654,498		40			654,498	7
8			1981	1981	718,104	74,348	40	74,348		718,104	8
	Improvement Type**										
9	1962 IMPROVEMENTS			1962	4,333		VARIOUS			4,333	9
10	1963 IMPROVEMENTS			1963	594		VARIOUS			594	10
11	1966 IMPROVEMENTS			1966	10,285		VARIOUS			10,285	11
12	1971 IMPROVEMENTS			1971	40,796		VARIOUS			40,796	12
13	1973 IMPROVEMENTS			1973	1,471		VARIOUS			1,471	13
14	1974 IMPROVEMENTS			1974	1,162		VARIOUS			1,162	14
15	1975 IMPROVEMENTS			1975	7,723		VARIOUS			7,723	15
16	1976 IMPROVEMENTS			1976	75,575		VARIOUS			75,575	16
17	1977 IMPROVEMENTS			1977	13,703		VARIOUS			13,703	17
18	1978 IMPROVEMENTS			1978	24,680		VARIOUS			24,680	18
19	1979 IMPROVEMENTS			1979	454,801		VARIOUS			454,801	19
20	1980 IMPROVEMENTS			1980	5,908		VARIOUS			5,908	20
21	1982 IMPROVEMENTS			1982	7,078		VARIOUS			7,078	21
22	1983 IMPROVEMENTS			1983	43,908		VARIOUS			43,908	22
23	1984 IMPROVEMENTS			1984	8,251		VARIOUS			8,251	23
24	1985 IMPROVEMENTS			1985	2,783		VARIOUS			2,783	24
25	1986 IMPROVEMENTS			1986	17,209		VARIOUS			17,209	25
26	1987 IMPROVEMENTS			1987	169,475	7,011	VARIOUS	7,011		169,475	26
27	1989 IMPROVEMENTS			1989	38,131		VARIOUS			38,131	27
28	1991 IMPROVEMENTS			1991	105,345	1,116	VARIOUS	1,116		105,345	28
29	1992 IMPROVEMENTS			1992	54,391		VARIOUS			54,391	29
30	1993 IMPROVEMENTS			1993	6,300	630	VARIOUS	630		6,300	30
31	1994 IMPROVEMENTS			1994	45,495		VARIOUS			45,495	31
32	1995 IMPROVEMENTS			1995	21,589		VARIOUS			21,589	32
33	1996 IMPROVEMENTS			1996	71,312	2,743	VARIOUS	2,743		71,312	33
34	1997 IMPROVEMENTS			1997	105,997	5,502	VARIOUS	5,502		105,997	34
35	1998 IMPROVEMENTS			1998	56,115	4,368	VARIOUS	4,368		56,115	35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number ST PAULS HOME # 0013920 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	
37	1999 IMPROVEMENTS	1999	$ 24,704	$	VARIOUS	$	$	$ 24,704	37
38	2000 IMPROVEMENTS	2000	29,955	3,365	VARIOUS	3,365		29,955	38
39	2001 IMPROVEMENTS	2001	62,410	11,461	VARIOUS	11,461		62,410	39
40	2002 IMPROVEMENTS	2002	89,661	6,454	VARIOUS	6,454		89,661	40
41	2003 IMPROVEMENTS	2003	31,961	995	VARIOUS	995		31,961	41
42	2004 IMPROVEMENTS	2004	58,035	10,614	VARIOUS	10,614		58,035	42
43	2005 IMPROVEMENTS	2005	74,581	8,573	VARIOUS	8,573		74,581	43
44	Repair Bathroom Ceiling Lower Roediger	2006	1,061	106	10	106		1,004	44
45	Architect services for Life Safety Code (LSC)	2006	2,148	215	10	215		2,032	45
46	Furnish & Install Ductwork from grill to handler K-029	2006	2,168	217	10	217		2,042	46
47	Reception Wired Mirror Replacement K-019	2006	800	80	10	80		750	47
48	Sprinkler Head and Drain K-056	2006	1,048	105	10	105		983	48
49	Install duct detector and modules K-067 and K-029	2006	1,560	156	10	156		1,463	49
50	Revision to UL 300 standards- Fire Suppression System	2006	725	73	10	73		683	50
51	Architect services for Life Safety Code	2006	503	50	10	50		474	51
52	Door replacement- Back doors	2006	589	59	10	59		547	52
53	Revision to UL 300 standards- Fire Suppression System	2006	721	72	10	72		676	53
54	Generator tubing line-new install w/labor	2006	652	65	10	65		605	54
55	Install fire proofiing in Roediger & Bartel- K025	2006	9,637	964	10	964		9,034	55
56	Smoke detector replacement	2006	556		5			556	56
57	Door replacement- Kitchen doors	2006	963	96	10	96		895	57
58	Front walk and railings- Life Safety Code	2006	25,913	2,591	10	2,591		23,970	58
59	New Boiler system for life safety code	2006	5,136	514	10	514		4,751	59
60	w/tubing installation to lines for life of safety code	2006	6,246	625	10	625		5,778	60
61	Replacement compressors for HVAC	2006	4,597	460	10	460		4,233	61
62	Architect services for Life Safety Code	2006	100	10	10	10		92	62
63	22 Fire Dampers and 10 Smoke Detectors for LSC	2006	18,242	1,824	10	1,824		16,798	63
64	Door Replacements- Life Safety Code	2006	4,613	461	10	461		4,248	64
65	Boiler Room Door repladement for Life Safety Codes	2006	6,517	652	10	652		5,974	65
66	Final invoice on new Boiler installment	2006	2,298	230	10	230		2,107	66
67	Life Safety Codes for Fire Duct Detectors	2006	4,077	408	10	408		3,737	67
68	Life Safety Code for Concrete Ramp, pad&railings, exit	2006	4,597	460	10	460		4,176	68
69	Architect for chages to ICF Wings	2006	2,500	250	10	250		2,260	69
70	TOTAL (lines 4 thru 69)		$ 3,827,769	$ 147,921		$ 147,921	$	$ 3,819,667	70

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

Facility Name & ID Number ST PAULS HOME # 0013920 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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 12A, Carried Forward		$ 3,827,769	$ 147,921		$ 147,921	$	$ 3,819,667	1
2	Medicare wing architects	2007	3,454	173	20	173		2,296	2
3	Wall guards for resident assistance	2007	850	85	10	85		751	3
4	Fire sprinkler enhancements	2007	994	99	10	99		878	4
5	New kitchen plumbing lines	2007	7,479	748	10	748		6,606	5
6	Medicare wing architects	2007	5,096	255	20	255		3,387	6
7	Medicare wing architects - 2 inv.	2007	2,664	133	20	133		1,771	7
8	Medicare wing architects	2007	4,543	227	20	227		3,019	8
9	Cooling Tower Replacement- 2 amts	2007	995	99	20	99		870	9
10	Medicare wing architects 2 inv	2007	4,048	202	10	202		2,690	10
11	Medicare wing architects	2007	1,272	64	20	64		845	11
12	Medicare wing architects	2007	18,255	913	20	913		12,132	12
13	Medicare wing architects	2007	2,700	135	20	135		1,794	13
14	Medicare wing architects	2007	320	16	20	16		213	14
15	Medicare wing architects	2007	4,394	220	20	220		2,920	15
16	Install Blower and MotorHVAC	2007	1,513	76	20	76		1,040	16
17	Medicare wing architects - 2 inv.	2007	1,288	64	20	64		856	17
18	Medicare wing - Crawl space abatement	2007	856	43	20	43		569	18
19	Medicare wing - Roediger fireproofing	2007	18,661	933	20	933		12,402	19
20	Medicare wing architects	2007	5,586	279	20	279		3,712	20
21	Medicare wing - Roediger fireproofing	2007	50,455	2,523	20	2,523		33,532	21
22	Medicare wing architects	2007	1,292	65	20	65		859	22
23	Medicare wing architgects	2008	3,277	164	20	164		2,178	23
24	Medicare wing - construction	2008	68,205	3,410	20	3,410		45,328	24
25	5 ton, 3 stage AC	2008	5,036	504	10	504		4,176	25
26	Medicare wing - construction	2008	68,883	3,444	20	3,444		45,778	26
27	Medicare wing architects	2008	1,380	69	20	69		917	27
28	Medicare wing construction staffing	2008	767	38	20	38		510	28
29	Moved Pneumatic Thermostats	2008	552	55	10	55		458	29
30	Medicare wing architects	2008	8,251	413	20	413		5,483	30
31	Medicare wing architects	2008	564	28	20	28		375	31
32	Medicare wing construction	2008	1,735	87	20	87		1,153	32
33	Medicare wing construction	2008	47,296	2,365	20	2,365		31,432	33
34	TOTAL (lines 1 thru 33)		$ 4,170,430	$ 165,849		$ 165,849	$	$ 4,050,597	34

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

Facility Name & ID Number ST PAULS HOME # 0013920 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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 12B, Carried Forward		$ 4,170,430	$ 165,849		$ 165,849	$	$ 4,050,597	1
2	Medicare wing construction	2008	920	46	20	46		611	2
3	Concrete work, steps, ramp Nrsg	2008	10,250	513	20	513		6,769	3
4	Kitchinette	2008	1,666	167	10	167		1,340	4
5	rehab unit, nursing, common areas	2008	30,000	1,500	20	1,500		19,688	5
6	Railings for nursing home	2008	3,150	158	20	158		2,061	6
7	Roediger Railings, Steam Tables	2009	1,971	214	5	214		1,971	7
8	Dietary Steam table set up	2009	842	98	5	98		842	8
9	Door replacement, Back entrance	2009	1,070	107	10	107		838	9
10	Parking lot	2009	2,840	284	10	284		2,189	10
11	Rehab unit	2009	4,249	212	20	212		2,806	11
12	Soffit & Fascia - Home building	2009	27,044	1,352	20	1,352		17,128	12
13	Kitchinette	2009	6,350	635	10	635		5,186	13
14	Soffit & Fascia - Home building	2009	590	103	5	103		590	14
15	Rooftop Condensor Unit - HVAC	2009	11,190	1,119	10	1,119		8,532	15
16	Butterfly Valve for HVAC	2009	1,471	147	10	147		1,122	16
17	Dining Room Bartel	2009	770	77	10	77		577	17
18	Carpet 3600 sq ft. dining room	2009	12,010	1,201	10	1,201		9,007	18
19	Dining Room Bartel	2009	1,425	143	10	143		1,069	19
20	Dining Room Bartel	2009	2,361	236	10	236		1,770	20
21	Dining Room improvements for SNF Bartel	2010	1,791	179	10	179		1,336	21
22	25 ton air condensing unit in Chapel area	2010	18,538	927	20	927		11,432	22
23	Fire Sprinkler move for Hallway/Storage room	2010	1,960	196	10	196		1,437	23
24	Dining Room improvements for SNF Bartel	2010	230	23	10	23		168	24
25	Outside and Inside back door	2010	5,845	585	10	585		4,262	25
26	Draperies for dining room improvement for SNF bartel	2010	1,443	144	10	144		1,052	26
27	Dining Room improvements for SNF Bartel	2010	5,977	598	10	598		4,283	27
28	Dining Room improvements for SNF Bartel	2010	464	46	10	46		325	28
29	Ludwig sewer replacement	2011	841	84	10	84		585	29
30	Power unit and hydraulic	2011	9,347	935	10	935		6,465	30
31	Replacement of Outer Door	2012	2,659	266	10	266		1,684	31
32	Damper infrastructure changes	2012	1,494	149	10	149		947	32
33	Grounded Compressor replacements, Bartel Chiller	2012	10,809	1,081	10	1,081		7,296	33
34	TOTAL (lines 1 thru 33)		$ 4,351,998	$ 179,373		$ 179,373	$	$ 4,175,966	34

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

Facility Name & ID Number ST PAULS HOME # 0013920 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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 12C, Carried Forward		$ 4,351,998	$ 179,373		$ 179,373	$	$ 4,175,966	1
2	Generator replacement and infrastructure to boilers	2012	49,838	7,769	10	7,769		34,737	2
3	Compressor replacement and infrastructure	2012	15,782	1,578	10	1,578		6,050	3
4	Air Conditioning units- 3	2009	1,335	211	5	211		1,335	4
5	Compressor for Laundry A/C	2014	3,016	25	10	25		25	5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,421,968	$ 188,956		$ 188,956	$	$ 4,218,113	34

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

Facility Name & ID Number ST PAULS HOME # 0013920 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	$ 2,123,403	$ 132,686	$ 132,686	$		$ 1,996,253	71
72	Current Year Purchases	8,680	1,225	1,225			1,225	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 2,132,083	$ 133,911	$ 133,911	$		$ 1,997,478	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	VAN	FORD ECONOLINE 1992	1993	$ 550	$	$	$		$ 550	76
77	VAN IMPROVEMENTS	ECONOLINE VAN LIFT '92	95, '96, '97	18,395					18,395	77
78	PATIENT TRANSPORT	BUICK LESABRE 1995	2009	15,329	2,190	2,190		7	10,949	78
79	PATIENT TRANSPORT	CHEVY IMPALA 2006	2009	16,505	2,358	2,358		7	11,789	79
80	TOTALS			$ 50,779	$ 4,548	$ 4,548	$		$ 41,684	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 6,627,526	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 327,415	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 327,415	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)	$ 6,257,274	85	

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	CATAWBA BLDG & LAND	$ 244,051	$ 3,510	$ 93,675	86
87	APARTMENT LAND	83,097			87
88	APARTMENT BUILDING	5,434,114	138,870	3,243,860	88
89	APARTMENT EQUIP & COMP	272,994	4,969	263,841	89
90	APARTMENT VEHICLES	34,262		34,262	90
91	TOTALS	$ 6,068,518	$ 147,349	$ 3,635,638	91

G. Construction-in-Progress

	Description	Cost	
92	NEW BUILDING 2015	$ 18,283,787	92
93	Cap Interest	440,657	93
94	Deferred Marketing	4,908	94
95		$ 18,729,352	95

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

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

Facility Name & ID Number ST PAULS HOME # 0013920 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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 [X] 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.	/2015	$
13.	/2016	$
14.	/2017	$

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

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 6,872 Description: Copier
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number ST PAULS HOME # 0013920 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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.

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a	hrs	$	2,898	$ 138,551	$	2,898	$ 138,551	1
2	Licensed Speech and Language Development Therapist	10a	hrs		1,631	116,678		1,631	116,678	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	hrs		3,402	171,649		3,402	171,649	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$	7,931	$ 426,878	$	7,931	$ 426,878	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 PAULS HOME # 0013920 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2014 (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	$ 379,280	$	1
2	Cash-Patient Deposits	60,020		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 253,000)	1,908,675		3
4	Supply Inventory (priced at)	23,819		4
5	Short-Term Investments			5
6	Prepaid Insurance	(91,526)		6
7	Other Prepaid Expenses	212,503		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Stanc Assets/COI 1st Bnk	962,937		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,455,708	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	22,696		13
14	Buildings, at Historical Cost	3,559,723		14
15	Leasehold Improvements, at Historical Cost	862,245		15
16	Equipment, at Historical Cost	2,182,862		16
17	Accumulated Depreciation (book methods)	(6,257,275)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):	18,729,352		22
23	Other(specify): ASSISTED LIVING	2,432,882		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 21,532,485	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 24,988,193	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,150,905	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	69,060		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	33,167		30
31	Accrued Taxes Payable (excluding real estate taxes)	13,126		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	368,843		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	CIP NOT YET DRAWN ON LOAN	1,127,388		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,762,489	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	17,746,162		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	ASSISTED LIVING	69,590		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 17,815,752	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 20,578,241	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 4,409,952	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 24,988,193	$	48

***(See instructions.)**

Facility Name & ID Number ST PAULS HOME # 0013920 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 4,662,343	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 4,662,343	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(252,391)	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)**	$ (252,391)	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)**	$ 4,409,952	24	*

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

Facility Name & ID Number ST PAULS HOME # 0013920 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,906,787	1
2	Discounts and Allowances for all Levels	(1,165,770)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,741,017	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,237,342	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,237,342	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	7,264	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	49,455	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	1,796	19
20	Radiology and X-Ray	4,269	20
21	Other Medical Services	98,292	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 161,076	23
	D. Non-Operating Revenue		
24	Contributions	85,000	24
25	Interest and Other Investment Income***	7,444	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 92,444	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	OTHER INCOME	21,299	28
28a	ASSISTED LIVING INCOME	276,067	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 297,366	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,529,245	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,410,814	31
32	Health Care	2,736,638	32
33	General Administration	1,744,886	33
	B. Capital Expense		
34	Ownership	445,418	34
	C. Ancillary Expense		
35	Special Cost Centers	175,961	35
36	Provider Participation Fee	267,919	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,781,636	40
41	**Income before Income Taxes (line 30 minus line 40)****	(252,391)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (252,391)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,953,348	44
45	Private Pay - Net Inpatient Revenue	2,490,475	45
46	Medicare - Net Inpatient Revenue	462,964	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,906,787	49

* **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 PAULS HOME # 0013920 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	1,615	1,615	$ 80,079	$ 49.58	1
2	Assistant Director of Nursing	1,615	1,615	66,150	40.96	2
3	Registered Nurses	7,518	7,518	197,562	26.28	3
4	Licensed Practical Nurses	27,243	27,243	569,133	20.89	4
5	CNAs & Orderlies	92,602	92,602	1,054,450	11.39	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	5,898	5,898	63,249	10.72	10
11	Social Service Workers	2,000	2,000	34,419	17.21	11
12	Dietician	30,284	30,284	364,692	12.04	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	8,019	8,019	105,302	13.13	17
18	Housekeepers	18,627	18,627	209,252	11.23	18
19	Laundry	9,918	9,918	101,934	10.28	19
20	Administrator	2,080	2,080	120,195	57.79	20
21	Assistant Administrator					21
22	Other Administrative	13,285	13,285	212,673	16.01	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	5,541	5,541	54,143	9.77	31
32	Other Health C: MDS COOR	1,615	1,615	66,877	41.41	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	227,860	227,860	$ 3,300,110 *	$ 14.48	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		$		35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$		49

C. CONTRACT NURSES

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

Facility Name & ID Number ST PAULS HOME # 0013920 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
SUSAN FRANKLIN	STAMS - Exe Dir	0	$ 14,730
CINDY WOODS (reclassed)	EXEC DIR	0	91,619
SHARRILL KRUEP (reclassed)	EXEC DIR	0	13,846
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 120,195

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
MATHIS, MARI, RICHTER	LEGAL - Tax exemption	$ 3,199
LOWENBAUM	LEGAL - HR issues	2,978
MATHIS, MARI, RICHTER	LEGAL	27,069
DANIEL MAHER LAW	LEGAL	1,860
VARIOUS	PAYROLL/COMPUTER	31,908
BKD LLP	AUDIT/TAX/COST REPORT	29,065
ST ANDREWS MGT SVS	MANAGEMENT FEES	370,778
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 466,857

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 98,492
Unemployment Compensation Insurance	31,427
FICA Taxes	281,854
Employee Health Insurance	309,655
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
LIFE INSURANCE	3,675
TOTAL (agree to Schedule V, line 22, col.8)	$ 725,103

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,537
Advertising: Employee Recruitment	10,028
Health Care Worker Background Check	
(Indicate # of checks performed 25)	877
EMPLOYEE EVENTS	5,186
RESIDENT BACKGROUND CHECK	480
DUES & SUBSCRIPTIONS	7,940
PUBLIC RELATIONS	36,492
Less: Public Relations Expense	(36,492)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 26,048

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	3,363
Seminar Expense	6,003
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 9,366

**See instructions.

Facility Name & ID Number ST PAULS HOME # 0013920 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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 PAULS HOME # 0013920 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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. **$7,866.70 Leading Age**

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

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **37,923** 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. $ **267,919**
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. $ **NONE** Has any meal income been offset against related costs? **NO** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **YES**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **YES**
Firm Name: **BKD, 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.