		FOR BHF USE					

LL1

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.

2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

I. IDPH License ID Number: 0053629

Facility Name: St. Paul's 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:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code	501(c)(3)		Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Kevin Wellen **Telephone Number:** 314-925-4446
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 1/01/2017 to 12/31/2017 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, CPA, Director
(Firm Name & Address) CliftonLarsonAllen, LLP, 600 Washington Ave. Suite 1800, St. Louis, MO 63101
(Telephone) 314-925-4446 Fax # 314-925-4350

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 Home # 0053629 Report Period Beginning: 1/01/2017 Ending: 12/31/2017

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	90	Skilled (SNF)	90	32,850	1
2		Skilled Pediatric (SNF/PED)			2
3	18	Intermediate (ICF)	18	6,570	3
4		Intermediate/DD			4
5	26	Sheltered Care (SC)	26	9,490	5
6		ICF/DD 16 or Less			6
7	134	TOTALS	134	48,910	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	7,965	15,258	5,785	29,008	8
9	SNF/PED					9
10	ICF	1,091	3,744		4,835	10
11	ICF/DD					11
12	SC		6,585		6,585	12
13	DD 16 OR LESS					13
14	TOTALS	9,056	25,587	5,785	40,428	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.66%

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

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Outpatient therapy services to ILU, SC/SH Residents

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

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

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

I. On what date did you start providing long term care at this location?
Date started 1926

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 90 and days of care provided 5,155

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2017 Fiscal Year: 12/31/2017

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

Facility Name & ID Number St. Paul's Home # 0053629 Report Period Beginning: 1/01/2017 Ending: 12/31/2017

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	567,860	23,934	8,121	599,915		599,915	(6,926)	592,989			1
2	Food Purchase		290,142		290,142		290,142		290,142			2
3	Housekeeping	2,072	21,044		23,116		23,116		23,116			3
4	Laundry	69,186	12,302		81,488		81,488		81,488			4
5	Heat and Other Utilities			210,919	210,919		210,919		210,919			5
6	Maintenance	112,167	2,718	82,809	197,694		197,694		197,694			6
7	Other (specify):*											7
8	**TOTAL General Services**	751,285	350,140	301,849	1,403,274		1,403,274	(6,926)	1,396,348			8
	B. Health Care and Programs											
9	Medical Director			15,900	15,900		15,900		15,900			9
10	Nursing and Medical Records	2,969,730	79,467	83,577	3,132,774		3,132,774		3,132,774			10
10a	Therapy											10a
11	Activities	66,823	4,687	2,759	74,269		74,269		74,269			11
12	Social Services	50,824			50,824		50,824		50,824			12
13	CNA Training											13
14	Program Transportation			1,126	1,126		1,126	(1,095)	31			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,087,377	84,154	103,362	3,274,893		3,274,893	(1,095)	3,273,798			16
	C. General Administration											
17	Administrative	111,072			111,072		111,072		111,072			17
18	Directors Fees											18
19	Professional Services			769,504	769,504		769,504		769,504			19
20	Dues, Fees, Subscriptions & Promotions			27,749	27,749		27,749		27,749			20
21	Clerical & General Office Expenses	135,910	24,334	453,118	613,362		613,362	(474,269)	139,093			21
22	Employee Benefits & Payroll Taxes			1,057,848	1,057,848		1,057,848		1,057,848			22
23	Inservice Training & Education			55	55		55		55			23
24	Travel and Seminar			12,946	12,946		12,946		12,946			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			90,986	90,986		90,986		90,986			26
27	Other (specify):*											27
28	**TOTAL General Administration**	246,982	24,334	2,412,206	2,683,522		2,683,522	(474,269)	2,209,253			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,085,644	458,628	2,817,417	7,361,689		7,361,689	(482,290)	6,879,399			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 Home #0053629 **Report Period Beginning:** 1/01/2017 **Ending:** 12/31/2017

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			1,031,070	1,031,070		1,031,070		1,031,070			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,419,174	1,419,174		1,419,174	(382)	1,418,792			32
33	Real Estate Taxes			731	731		731	(731)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			11,501	11,501		11,501		11,501			35
36	Other (specify):*											36
37	**TOTAL Ownership**			2,462,476	2,462,476		2,462,476	(1,113)	2,461,363			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		187,208	947,498	1,134,706		1,134,706		1,134,706			39
40	Barber and Beauty Shops			62	62		62		62			40
41	Coffee and Gift Shops			383	383		383		383			41
42	Provider Participation Fee			234,813	234,813		234,813		234,813			42
43	Other (specify):* ILU	365,890	134,089	874,207	1,374,186		1,374,186	(1,374,186)				43
44	**TOTAL Special Cost Centers**	365,890	321,297	2,056,963	2,744,150		2,744,150	(1,374,186)	1,369,964			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,451,534	779,925	7,336,856	12,568,315		12,568,315	(1,857,589)	10,710,726			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 Home # 0053629 Report Period Beginning: 1/01/2017 Ending: 12/31/2017

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	(6,926)	1		4
5	Telephone, TV & Radio in Resident Rooms	(34,497)	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	(382)	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)	(1,095)	14		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(483)	21		19
20	Contributions	(285)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(342,593)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See PG5A	(1,471,328)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,857,589)		$	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))**	$ (1,857,589)		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. Paul's Home

ID# 0053629

Report Period Beginning: 1/01/2017

Ending: 12/31/2017

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Other Income	$ (96,411)	21	1
2	Independent Living Expenses	(1,374,186)	43	2
3	Real Estate Tax	(731)	33	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**	(1,471,328)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number St. Paul's Home # 0053629 **Report Period Beginning:** 1/01/2017 **Ending:** 12/31/2017

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 TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	(6,926)	0	0	0	0	0	0	0	0	0	0	(6,926)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(6,926)	0	0	0	0	0	0	0	0	0	0	(6,926)	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	0	0	0	0	0	0	0	0	0	0	0	0	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	(1,095)	0	0	0	0	0	0	0	0	0	0	(1,095)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(1,095)	0	0	0	0	0	0	0	0	0	0	(1,095)	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	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(474,269)	0	0	0	0	0	0	0	0	0	0	(474,269)	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**	(474,269)	0	0	0	0	0	0	0	0	0	0	(474,269)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(482,290)	0	0	0	0	0	0	0	0	0	0	(482,290)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number St. Paul's Home **#** 0053629 **Report Period Beginning:** 1/01/2017 **Ending:** 12/31/2017

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(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	(382)	0	0	0	0	0	0	0	0	0	0	(382)	32
33	Real Estate Taxes	(731)	0	0	0	0	0	0	0	0	0	0	(731)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(1,113)	0	0	0	0	0	0	0	0	0	0	(1,113)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(1,374,186)	0	0	0	0	0	0	0	0	0	0	(1,374,186)	43
44	**TOTAL Special Cost Centers**	(1,374,186)	0	0	0	0	0	0	0	0	0	0	(1,374,186)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(1,857,589)	0	0	0	0	0	0	0	0	0	0	(1,857,589)	45

Facility Name & ID Number St. Paul's Home # 0053629 Report Period Beginning: 1/01/2017 Ending: 12/31/2017

VII. RELATED PARTIES

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

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] 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. Paul's Home # 0053629 Report Period Beginning: 1/01/2017 Ending: 12/31/2017

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	Christine Mueller	BOD						1
2	Beverly Brightwell	BOD						2
3	Betty Lepard	BOD						3
4	Thomas Mentzer	BOD						4
5	Cary Smith	BOD						5
6	Jason Karstens	BOD						6
7	Bob DeCamp	BOD						7
8	Allen Scharf	BOD						8
9	Rev. Robert Koepcke	BOD						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. Paul's Home # 0053629 Report Period Beginning: 1/01/2017 Ending: 12/31/2017

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

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

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

Facility Name & ID Number St. Paul's Home # 0053629 Report Period Beginning: 1/01/2017 Ending: 2/31/2017

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. Paul's Home # 0053629 Report Period Beginning: 1/01/2017 Ending: 12/31/2017

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 Loans	Varies	12/10/13	$ 21,600,000	$ 20,664,864	6/10/19	0.0450	$ 804,874	1
2	The Good Samaritan Independent Liv		X	Subordinated Loan Payable	Varies	12/10/13	3,500,000	4,107,093	12/10/26	0.0700	308,600	2
3	St. Andrew's Resources for Seniors		X	Subordinated Loan Payable	Varies	12/10/13	1,500,000	1,760,183	12/10/26	0.0700	132,257	3
4	Cost of Issuance							(243,627)			173,443	4
5	Interest Income Offset										(382)	5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 26,600,000	$ 26,288,513			$ 1,418,792	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 26,600,000	$ 26,288,513			$ 1,418,792	15

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

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

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

Facility Name & ID Number St. Paul's Home # 0053629 **Report Period Beginning:** 1/01/2017 **Ending:** 12/31/2017

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 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 2017 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:			
	2012		8
	2013		9
	2014		10
	2015		11
	2016		12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2016	$	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.

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME St. Paul's Home COUNTY St. Clair

FACILITY IDPH LICENSE NUMBER 0053629

CONTACT PERSON REGARDING THIS REPORT Kevin Wellen

TELEPHONE 314-925-4300 FAX #: 314-925-4350

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

Enter the tax index number and real estate tax assessed for 2016 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 2016.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.		Non-SNF related	$ 1,548.00	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 1,548.00	$

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 X 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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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 Home # 0053629 Report Period Beginning: 1/01/2017 Ending: 12/31/2017

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? [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).

St. Paul's Home consists of 90 skilled beds, 26 shelter beds, 18 memory care beds, and 53 apartments.

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [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	Resident Use	178,000	1926	$ 22,696	1
2					2
3	TOTALS	178,000		$ 22,696	3

Facility Name & ID Number St. Paul's Home # 0053629 Report Period Beginning: 1/01/2017 Ending: 12/31/2017

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	90		2015	2015	$ 18,059,737	$ 451,493	40	$ 451,493	$	$ 1,079,835	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	1981 IMPROVEMENTS			1981	10,965		15			10,965	9
10	1982 IMPROVEMENTS			1982	3,200		15			3,200	10
11	1983 IMPROVEMENTS			1983	4,380		15			4,380	11
12	1987 IMPROVEMENTS			1987	112,643		VARIOUS			112,643	12
13	1996 IMPROVEMENTS			1996	19,617		VARIOUS			19,617	13
14	1997 IMPROVEMENTS			1997	12,290		VARIOUS			12,290	14
15	SNF Building - Tools & Equipment			2015	15,473	2,210	7	2,210		5,342	15
16	SNF Building - Asphalt Paving			2015	167,386	20,923	8	20,923		50,565	16
17	SNF Building - Landscaping and Irrigation			2015	209,910	20,991	10	20,991		50,728	17
18	SNF Building - Carpentry			2015	273,402	18,227	15	18,227		44,048	18
19	SNF Building - General Door Openings			2015	754,955	37,748	20	37,748		91,224	19
20	SNF Building - Automatic Doors & Operators			2015	11,666	1,167	10	1,167		2,819	20
21	SNF Building - Ceramic Tile			2015	299,865	14,993	20	14,993		36,234	21
22	SNF Building - Flooring			2015	368,589	18,429	20	18,429		44,538	22
23	SNF Building - Painting & Wallcovering			2015	298,517	59,703	5	59,703		144,283	23
24	SNF Building - Residential Appliances			2015	136,074	13,607	10	13,607		32,885	24
25	SNF Building - Commercial Laundry Equipment			2015	51,208	3,414	15	3,414		8,250	25
26	SNF Building - HVAC			2015	1,710,935	85,547	20	85,547		206,738	26
27	SNF Building - Plumbing			2015	1,345,918	67,296	20	67,296		162,632	27
28	Costs of Issuance (Construction Draws)			2015	273,314	6,833	40	6,833		23,677	28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number St. Paul's Home # 0053629 Report Period Beginning: 1/01/2017 Ending: 12/31/2017

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	$ 1,421,828	$ 201,818	$ 201,818	$	Various	$ 548,410	71
72	Current Year Purchases	1,478	353	353		3	1,478	72
73	Fully Depreciated Assets	103,130	1,341	1,341		Various	103,130	73
74								74
75	TOTALS	$ 1,526,436	$ 203,512	$ 203,512	$		$ 653,018	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	Patient Transport	Ford Econoline Van 1992	1993	$ 18,945	$	$	$	7	$ 18,945	76
77	Patient Transport	95 LeSabre & 06 Impala	2009	31,834				7	31,834	77
78	Patient Transport	2007 Van	2016	32,500	4,643	4,643		7	6,578	78
79	Patient Transport	Van from Brooking Park	2017	10,000	333	333		5	333	79
80	TOTALS			$ 93,279	$ 4,976	$ 4,976	$		$ 57,690	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)	$ 25,782,455	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 1,031,070	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 1,031,070	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)	$ 2,857,601	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Apartment Land	$ 83,097	$	$	86
87	Apartment Building	6,014,425	155,485	3,661,884	87
88	Apartment Equipment	268,225	13,453	257,072	88
89	Apartment Vehicles	34,262		34,262	89
90					90
91	TOTALS	$ 6,400,009	$ 168,938	$ 3,953,218	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 Home # 0053629 Report Period Beginning: 1/01/2017 Ending: 12/31/2017

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [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.	/2018	$
13.	/2019	$
14.	/2020	$

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: $ 11,501 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. Paul's Home # 0053629 Report Period Beginning: 1/01/2017 Ending: 12/31/2017

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 Home

STATE OF ILLINOIS
0053629 Report Period Beginning: 1/01/2017 Ending: 12/31/2017

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	V39-3	hrs	$	7,733	$ 372,140	$	7,733	$ 372,140	1
2	Licensed Speech and Language Development Therapist	V39-3	hrs		3,249	175,338		3,249	175,338	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	V39-3	hrs		6,514	340,529		6,514	340,529	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	V39-2	# of prescrpts				140,324		140,324	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Billable Supplies						46,884		46,884	12
13	Other (specify): Equip Rental/Lab/Xray					59,491			59,491	13
14	TOTAL			$	17,496	$ 947,498	$ 187,208	17,496	$ 1,134,706	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 Home # 0053629 **Report Period Beginning:** 1/01/2017 **Ending:** 12/31/2017

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2017 (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	$ 732,182	$	1
2	Cash-Patient Deposits	16,811		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 428,158)	1,465,323		3
4	Supply Inventory (priced at)	26,497		4
5	Short-Term Investments	30,360		5
6	Prepaid Insurance	132,657		6
7	Other Prepaid Expenses	21,748		7
8	Accounts Receivable (owners or related parties)	475,553		8
9	Other(specify): Other AR	59,444		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,960,575	$	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	18,059,737		14
15	Leasehold Improvements, at Historical Cost	6,080,307		15
16	Equipment, at Historical Cost	1,619,715		16
17	Accumulated Depreciation (book methods)	(2,857,601)		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):			22
23	Other(specify): ILU	2,446,791		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 25,371,645	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 28,332,220	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 615,080	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	16,918		28
29	Short-Term Notes Payable	476,881		29
30	Accrued Salaries Payable	199,272		30
31	Accrued Taxes Payable (excluding real estate taxes)	11,109		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	744,718		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Other Accrued Expenses	147,458		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,211,436	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	25,811,632		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	101,211		42
	Other Long-Term Liabilities(specify):			
43	Deposits	16,500		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 25,929,343	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 28,140,779	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 191,441	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 28,332,220	$	48

***(See instructions.)**

Facility Name & ID Number St. Paul's Home **#** 0053629 **Report Period Beginning:** 1/01/2017 **Ending:** 12/31/2017

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,524,084	1
2	Restatements (describe):		2
3	**Rounding**	1	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,524,085	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,332,644)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (1,332,644)	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)**	$ 191,441	24 *

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

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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	$ 8,620,860	1
2	Discounts and Allowances for all Levels	(1,602,634)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,018,226	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,399,621	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,399,621	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	6,926	14
15	Telephone, Television and Radio	2,940	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients	138,048	18
19	Laboratory	5,288	19
20	Radiology and X-Ray	8,219	20
21	Other Medical Services	66,613	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 228,034	23
	D. Non-Operating Revenue		
24	Contributions	120,000	24
25	Interest and Other Investment Income***	382	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 120,382	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Other Revenues/Losses	97,506	28
28a	ILU Revenue	1,371,902	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,469,408	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 11,235,671	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,403,274	31
32	Health Care	3,274,893	32
33	General Administration	2,683,522	33
	B. Capital Expense		
34	Ownership	2,462,476	34
	C. Ancillary Expense		
35	Special Cost Centers	2,509,337	35
36	Provider Participation Fee	234,813	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 12,568,315	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,332,644)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,332,644)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,208,948	44
45	Private Pay - Net Inpatient Revenue	4,868,431	45
46	Medicare - Net Inpatient Revenue	940,847	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 7,018,226	49

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

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

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

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

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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
2	Assistant Director of Nursing					2
3	Registered Nurses	26,356	26,356	709,507	26.92	3
4	Licensed Practical Nurses	38,872	38,872	829,228	21.33	4
5	CNAs & Orderlies	118,080	118,080	1,430,995	12.12	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,929	3,929	66,823	17.01	10
11	Social Service Workers	2,988	2,988	50,824	17.01	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	53,913	53,913	567,860	10.53	15
16	Dishwashers					16
17	Maintenance Workers	8,595	8,595	112,167	13.05	17
18	Housekeepers	197	197	2,072	10.52	18
19	Laundry	6,569	6,569	69,186	10.53	19
20	Administrator	2,080	2,080	111,072	53.40	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,552	4,552	135,910	29.86	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)			0		32
33	Other(specify) ILU	40,964	40,964	365,890	8.93	33
34	TOTAL (lines 1 - 33)	307,095	307,095	$ 4,451,534 *	$ 14.50	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	175	$ 8,121	V01-3	35
36	Medical Director	Monthly	15,900	V09-3	36
37	Medical Records Consultant	31	1,775	V10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	11,957	V10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	40	1,980	V19-3	44
45	Social Service Consultant	40	1,980	V19-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	286	$ 41,713		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

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Sharrill Kruep	Exec Dir	0	$ 21,507
Tammy VonYeast	Exec Dir	0	69,029
Christy Utterback	Exec Dir	0	20,536
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 111,072

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
St. Andrew's Mgmt Services	Management Fee	$ 482,079
St. Andrew's Mgmt Services	IT & Computer Fees	178,522
St. Andrew's Mgmt Services	Biller Fees	29,372
CliftonLarsonAllen LLP	Audit, Tax, Cost Report	38,811
Health Technologies, Inc.	Consulting	6,287
Outcome Services of IL	Consulting	2,113
Misc. Other Vendors	Consulting	1,356
Kronos	Payroll Processing	2,764
Duane Morris	Legal Services	8,355
Greensfelder	Legal Services	5,307
Lowenbaum	Legal Services	3,741
Misc. Other Vendors	Legal Services	10,797
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 769,504

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 307,192
Unemployment Compensation Insurance	
FICA Taxes	369,014
Employee Health Insurance	379,204
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401k Employer Match	2,438
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,057,848

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

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 3,357
Advertising: Employee Recruitment	6,034
Health Care Worker Background Check	
(Indicate # of checks performed 143)	4,995
Resident Background Checks 77	1,530
Employee Events/Awards	1,012
Dues & Subscriptions	10,821
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 27,749

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 1,986
In-State Travel	
Mileage Reimb	5,562
Hotel	880
Seminar Expense	4,518
Entertainment Expense	(0)
TOTAL (agree to Sch. V, line 24, col. 8)	$ 12,946

* Attach copy of IMRF notifications

**See instructions.

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XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Leading Age $8,037**

(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? **3**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **30,521** Line **10**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **234,813**
This amount is to be recorded on line 42 of Schedule V.

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

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **6,926**

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

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

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? **Yes**
See page 39 of the instructions for details.
Attach invoices and a summary of services for all architect and appraisal fees