

		FOR BHF USE					

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2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

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.

<p>I. IDPH License ID Number: <u>0053629</u></p> <p>Facility Name: <u>St. Paul's Home</u></p> <p>Address: <u>1021 West E Street</u> <u>Belleville</u> <u>62220</u> <small>Number City Zip Code</small></p> <p>County: <u>St. Clair</u></p> <p>Telephone Number: <u>(618) 233-2095</u> Fax # <u>(628) 233-2109</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>Unable to Locate</u></p> <p>Type of Ownership:</p> <table style="width:100%"> <tr> <td><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input checked="" type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code <u>501(c)(3)</u></td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other</td> <td>_____</td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Kevin Wellen</u> Telephone Number: <u>(314) 925-4446</u> Email Address: _____</p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code <u>501(c)(3)</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.	_____		<input type="checkbox"/> Limited Liability Co.	_____		<input type="checkbox"/> Trust			<input type="checkbox"/> Other	_____	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2018</u> to <u>12/31/2018</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%"> <tr> <td style="width:20%; vertical-align: top;">Officer or Administrator of Provider</td> <td>(Signed) _____ (Type or Print Name) _____ (Title) _____</td> </tr> <tr> <td style="width:20%; vertical-align: top;">Paid Preparer</td> <td>(Signed) _____ (Print Name and Title) <u>Kevin Wellen, CPA</u> <u>Director</u> (Firm Name & Address) <u>CliftonLarsonAllen, LLP</u> <u>600 Washington Ave, Suite 1800, St. Louis, MO 63101</u> (Telephone) <u>(314) 925-4446</u> Fax # <u>(314) 925-4350</u></td> </tr> </table> <p align="right">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</p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) _____ (Title) _____	Paid Preparer	(Signed) _____ (Print Name and Title) <u>Kevin Wellen, CPA</u> <u>Director</u> (Firm Name & Address) <u>CliftonLarsonAllen, LLP</u> <u>600 Washington Ave, Suite 1800, St. Louis, MO 63101</u> (Telephone) <u>(314) 925-4446</u> Fax # <u>(314) 925-4350</u>
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																											
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Facility Name & ID Number St. Paul's Home

0053629 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	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 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	8,114	11,852	7,111	27,077	8
9	SNF/PED					9
10	ICF	1,111	2,908		4,019	10
11	ICF/DD					11
12	SC		5,115		5,115	12
13	DD 16 OR LESS					13
14	TOTALS	9,225	19,875	7,111	36,211	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.04%

D. How many bed reserve days during this year were paid by the Department?
None (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 NO

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 90 and days of care provided 5,787

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2018 Fiscal Year: 12/31/2018

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

Facility Name & ID Number St. Paul's Home # 0053629 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	640,627	23,848	9,527	674,002		674,002		674,002		1
2	Food Purchase		391,428		391,428		391,428	(4,084)	387,344		2
3	Housekeeping	208,568	24,749		233,317		233,317		233,317		3
4	Laundry	45,873	10,727		56,600		56,600		56,600		4
5	Heat and Other Utilities			270,396	270,396		270,396		270,396		5
6	Maintenance	128,350	4,610	165,378	298,338		298,338		298,338		6
7	Other (specify):*										7
8	TOTAL General Services	1,023,418	455,362	445,301	1,924,081		1,924,081	(4,084)	1,919,997		8
	B. Health Care and Programs										
9	Medical Director					18,000	18,000		18,000		9
10	Nursing and Medical Records	3,142,743	89,973	36,877	3,269,593	(18,000)	3,251,593		3,251,593		10
10a	Therapy										10a
11	Activities	89,491	7,050	8,423	104,964		104,964		104,964		11
12	Social Services	104,356			104,356		104,356		104,356		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,336,590	97,023	45,300	3,478,913		3,478,913		3,478,913		16
	C. General Administration										
17	Administrative	90,000			90,000		90,000		90,000		17
18	Directors Fees										18
19	Professional Services			749,935	749,935		749,935		749,935		19
20	Dues, Fees, Subscriptions & Promotions			112,655	112,655		112,655		112,655		20
21	Clerical & General Office Expenses	178,924	22,533	486,067	687,524		687,524	(267,482)	420,042		21
22	Employee Benefits & Payroll Taxes			1,185,125	1,185,125		1,185,125		1,185,125		22
23	Inservice Training & Education			732	732		732		732		23
24	Travel and Seminar			6,196	6,196		6,196		6,196		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			154,406	154,406		154,406		154,406		26
27	Other (specify):*										27
28	TOTAL General Administration	268,924	22,533	2,695,116	2,986,573		2,986,573	(267,482)	2,719,091		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,628,932	574,918	3,185,717	8,389,567		8,389,567	(271,566)	8,118,001		29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			1,180,660	1,180,660		1,180,660	16,153	1,196,813		30
31	Amortization of Pre-Op. & Org.			187,510	187,510		187,510		187,510		31
32	Interest			1,823,764	1,823,764		1,823,764	(2,310)	1,821,454		32
33	Real Estate Taxes			671	671		671		671		33
34	Rent-Facility & Grounds			16,340	16,340		16,340		16,340		34
35	Rent-Equipment & Vehicles										35
36	Other (specify):*										36
37	TOTAL Ownership			3,208,945	3,208,945		3,208,945	13,843	3,222,788		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		245,155	1,054,011	1,299,166		1,299,166		1,299,166		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			244,172	244,172		244,172		244,172		42
43	Other (specify):* Marketing			88,812	88,812		88,812	(88,812)			43
44	TOTAL Special Cost Centers		245,155	1,386,995	1,632,150		1,632,150	(88,812)	1,543,338		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,628,932	820,073	7,781,657	13,230,662		13,230,662	(346,535)	12,884,127		45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(4,084)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	16,153	30		9
10	Interest and Other Investment Income	(2,310)	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				18
19	Entertainment	(3,744)	21		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(263,738)	21		24
25	Fund Raising, Advertising and Promotional	(88,812)	43		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				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (346,535)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (346,535)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY							
48		49		50		51	

St. Paul's Home

ID# 0053629

Report Period Beginning: 1/1/2018

Ending: 12/31/2018

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
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
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	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number St. Paul's Home# 0053629

Report Period Beginning:

1/1/2018

Ending:

12/31/2018

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	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(4,084)	0	0	0	0	0	0	0	0	0	0	(4,084)	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	(4,084)	0	0	0	0	0	0	0	0	0	0	(4,084)	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	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	0	0	0	0	0	0	0	0	0	0	0	0	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	(267,482)	0	0	0	0	0	0	0	0	0	0	(267,482)	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	(267,482)	0	0	0	0	0	0	0	0	0	0	(267,482)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(271,566)	0	0	0	0	0	0	0	0	0	0	(271,566)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number St. Paul's Home

0053629

Report Period Beginning:

1/1/2018

Ending:

12/31/2018

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	16,153	0	0	0	0	0	0	0	0	0	0	16,153	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,310)	0	0	0	0	0	0	0	0	0	0	(2,310)	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	13,843	0	0	0	0	0	0	0	0	0	0	13,843	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):*	(88,812)	0	0	0	0	0	0	0	0	0	0	(88,812)	43
44	TOTAL Special Cost Centers	(88,812)	0	0	0	0	0	0	0	0	0	0	(88,812)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(346,535)	0	0	0	0	0	0	0	0	0	0	(346,535)	45

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

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

Facility Name & ID Number

St. Paul's Home

0053629

Report Period Beginning:

1/1/2018

Ending:

12/31/2018

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	Allen Scharf, Chairperson	BOD						1
2	Thomas Mentzer, Co-Chair	BOD						2
3	Beverly Brightwell, Co-Chair	BOD						3
4	Pam Nicholson, Secretary	BOD						4
5	Cary Smith	BOD						5
6	John Coers	BOD						6
7	Bob DeCamp	BOD						7
8	Wayne Caughman	BOD						8
9	Linda Steiner	BOD						9
10	Michelle Torigian	BOD						10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number

St. Paul's Home

0053629

Report Period Beginning:

1/1/2018

Ending:

12/31/2018

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number St. Paul's Home

0053629

Report Period Beginning:

1/1/2018

Ending: 2/31/2018

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

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

Facility Name & ID Number

St. Paul's Home

0053629

Report Period Beginning:

1/1/2018

Ending:

12/31/2018

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required				Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
	A. Directly Facility Related																
	Long-Term																
1	First Bank		X	Note Payable Term Loans	Varies	12/10/13	\$ 21,600,000	\$ 20,258,875	6/10/19	0.0450	\$ 1,365,178	1					
2	The Good Samaritan Independent Liv		X	Subordinated Loan Payable	Varies	12/10/13	3,500,000	4,195,194	12/10/26	0.0700	321,010	2					
3	St. Andrew's Resources for Seniors		X	Subordinated Loan Payable	Varies	12/10/13	1,500,000	1,797,940	12/10/26	0.0700	137,576	3					
4	Cost of Issuance							(72,268)				4					
5	Interest Income Offset										(2,310)	5					
	Working Capital																
6												6					
7												7					
8												8					
9	TOTAL Facility Related						\$ 26,600,000	\$ 26,179,741			\$ 1,821,454	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	\$ 26,179,741			\$ 1,821,454	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.)

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2017 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 2018 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	671 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.		\$	671 7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2013	8	
	2014	9	
	2015	10	
	2016	11	
	2017	12	
			FOR BHF USE ONLY
	13	FROM R. E. TAX STATEMENT FOR 2017 \$	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.

2017 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, CPA

TELEPHONE (314) 925--4446 FAX #: (314) 925-4350

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2017 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 2017.

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

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES 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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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:

1/1/2018

Ending:

12/31/2018

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

Blank lines for listing other business entities.

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.

Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and a final column with values 1, 2, 3. Row 1: Resident Use, 178,000, 1926, \$ 22,696, 1. Row 2: (blank), (blank), (blank), (blank), 2. Row 3: TOTALS, 178,000, (blank), \$ 22,696, 3.

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	90	2015	2015	\$ 18,059,737	\$ 451,493	40	\$ 451,493	\$	\$ 1,531,328	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		7,552	15
16	SNF Building - Asphalt Paving		2015	167,386	20,923	8	20,923		71,488	16
17	SNF Building - Landscaping and Irrigation		2015	209,910	20,991	10	20,991		71,719	17
18	SNF Building - Carpentry		2015	273,402	18,227	15	18,227		62,275	18
19	SNF Building - General Door Openings		2015	754,955	37,748	20	37,748		128,972	19
20	SNF Building - Automatic Doors & Operators		2015	11,666	1,167	10	1,167		3,986	20
21	SNF Building - Ceramic Tile		2015	299,865	14,993	20	14,993		51,227	21
22	SNF Building - Flooring		2015	368,589	18,429	20	18,429		62,967	22
23	SNF Building - Painting & Wallcovering		2015	298,517	59,703	5	59,703		203,986	23
24	SNF Building - Residential Appliances		2015	136,074	13,607	10	13,607		46,492	24
25	SNF Building - Commercial Laundry Equipment		2015	51,208	3,414	15	3,414		11,664	25
26	SNF Building - HVAC		2015	1,710,935	85,547	20	85,547		292,285	26
27	SNF Building - Plumbing		2015	1,345,918	67,296	20	67,296		229,928	27
28	Costs of Issuance (Construction Draws)		2015	273,314	6,833	40	6,833		30,510	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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 24,140,044	\$ 822,582		\$ 822,582	\$	\$ 2,969,474	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,423,306	\$ 360,683	\$ 360,683	\$	Various	\$ 754,944	71
72	Current Year Purchases	48,338	6,905	6,905		Various	6,905	72
73	Fully Depreciated Assets	103,130				Various	103,130	73
74								74
75	TOTALS	\$ 1,574,774	\$ 367,588	\$ 367,588	\$		\$ 864,979	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 Transportation	Ford Econoline Van	1992	\$ 18,945	\$	\$	\$	7	\$ 18,945	76
77	Patient Transportation	95 LeSabre & 06 Impala	2009	31,834				7	31,834	77
78	Patient Transportation	2007 Van	2016	32,500	4,643	4,643		7	11,221	78
79	Patient Transportation	Van from Brooking Park	2017	10,000	2,000	2,000		5	2,333	79
80	TOTALS			\$ 93,279	\$ 6,643	\$ 6,643	\$		\$ 64,333	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)	\$ 25,830,793	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 1,196,813	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 1,196,813	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)	\$ 3,898,786	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	6,014,972	162,362	3,824,246	87
88	Apartment Equipment	268,225	11,153	268,225	88
89	Apartment Vehicles	34,262		34,262	89
90					90
91	TOTALS	\$ 6,400,556	\$ 173,515	\$ 4,126,733	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: 1/1/2018

Ending: 12/31/2018

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions.

YES NO

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

	Fiscal Year Ending	Annual Rent
--	--------------------	-------------

12.	_____ /2019	\$ _____
13.	_____ /2020	\$ _____
14.	_____ /2021	\$ _____

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 16,340 Description: Copier Equip

(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.

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		1	2	3	4
		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.)

	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	\$	7,404	\$ 444,262	\$	7,404	\$ 444,262	1
2	Licensed Speech and Language Development Therapist	V39-3	hrs		2,367	142,013		2,367	142,013	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	V39-3	hrs		6,988	419,290	90	6,988	419,380	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				207,465		207,465	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): <u>See WTB</u>					48,446	37,600		86,046	13
14	TOTAL			\$	16,759	\$ 1,054,011	\$ 245,155	16,759	\$ 1,299,166	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.

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2018

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 38,313	\$	1
2	Cash-Patient Deposits	18,801		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,336,902		3
4	Supply Inventory (priced at)	26,497		4
5	Short-Term Investments			5
6	Prepaid Insurance	127,797		6
7	Other Prepaid Expenses	58,964		7
8	Accounts Receivable (owners or related parties)	89,289		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,696,563	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	105,793		13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	30,155,016		15
16	Equipment, at Historical Cost	1,970,540		16
17	Accumulated Depreciation (book methods)	(8,025,519)		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): Other Long-Term Assets	72,268		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 24,278,098	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 25,974,661	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,046,421	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	18,801		28
29	Short-Term Notes Payable	20,285,970		29
30	Accrued Salaries Payable	233,020		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	1,489,559		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Prelease Deposits	16,250		36
37	Other Accrued Expenses	450,000		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 23,540,021	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	6,127,125		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 6,127,125	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 29,667,146	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (3,692,485)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 25,974,661	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (895,666)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (895,666)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(2,796,819)	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)	\$ (2,796,819)	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)	\$ (3,692,485)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number St. Paul's Home

0053629

Report Period Beginning: 1/1/2018

Ending: 12/31/2018

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required**classifications of revenue and expense must be provided on this form, even if financial statements are attached.****Note: This schedule should show gross revenue and expenses. Do not net revenue against expense**

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 5,831,916	1
2	Discounts and Allowances for all Levels	(1,238,122)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,593,794	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,479,919	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,479,919	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	4,084	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	143,482	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	11,079	19
20	Radiology and X-Ray		20
21	Other Medical Services	64,748	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 223,393	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	2,310	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,310	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Other Revenue (See WTB)	3,134,427	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 3,134,427	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,433,843	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,924,081	31
32	Health Care	3,478,913	32
33	General Administration	2,986,573	33
B. Capital Expense			
34	Ownership	3,208,945	34
C. Ancillary Expense			
35	Special Cost Centers	1,387,978	35
36	Provider Participation Fee	244,172	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 13,230,662	40
41	Income before Income Taxes (line 30 minus line 40)**	(2,796,819)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (2,796,819)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,121,309	44
45	Private Pay - Net Inpatient Revenue	2,229,610	45
46	Medicare - Net Inpatient Revenue	1,242,875	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,593,794	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. Paul's Home

0053629

Report Period Beginning: 1/1/2018

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing		\$	\$	1	
2	Assistant Director of Nursing				2	
3	Registered Nurses	22,734	24,385	797,779	32.72	3
4	Licensed Practical Nurses	30,915	35,656	847,253	23.76	4
5	CNAs & Orderlies	96,886	108,827	1,497,711	13.76	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,403	3,513	89,491	25.47	10
11	Social Service Workers	5,320	5,556	104,356	18.78	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	54,216	56,907	640,627	11.26	15
16	Dishwashers					16
17	Maintenance Workers	7,429	7,658	128,350	16.76	17
18	Housekeepers	17,451	18,022	208,568	11.57	18
19	Laundry	3,905	4,154	45,873	11.04	19
20	Administrator	2,080	2,080	90,000	43.27	20
21	Assistant Administrator					21
22	Other Administrative	5,542	5,723	178,924	31.26	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					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	249,881	272,481	\$ 4,628,932 *	\$ 16.99	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly \$ 9,527	V01-3	35
36	Medical Director	Monthly 18,000	V09-3	36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	Monthly 1,492	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			44
45	Social Service Consultant			45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 29,019		49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Tammy Von Yeast	Exec Director		\$ 90,000	Workers' Compensation Insurance	\$ 272,020	IDPH License Fee	\$	
				Unemployment Compensation Insurance		Advertising: Employee Recruitment	5,492	
				FICA Taxes	398,184	Health Care Worker Background Check		
				Employee Health Insurance	507,056	(Indicate # of checks performed _____)		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	12,945	
				Other Benefits	7,865	Licenses	94,218	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 90,000	TOTAL (agree to Schedule V, line 22, col.8)			\$ 1,185,125	
(List each licensed administrator separately.)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
B. Administrative - Other				Description	Line #	Amount	Description	Amount
N/A				N/A		\$	Out-of-State Travel	\$
TOTAL (agree to Schedule V, line 17, col. 3)				TOTAL			In-State Travel	
(Attach a copy of any management service agreement)							Seminar Expense	6,196
C. Professional Services				Vendor/Payee	Type	Amount	Entertainment Expense (agree to Sch. V, line 24, col. 8)	
							TOTAL	
				Legal	Accrual	\$ 71,370	\$ 6,196	
				CliftonLarsonAllen LLP	Accounting/Cost Report	32,766		
				St Andrews Management Service Inc	Data Processing	15,096		
				Direct Supply	Data Processing	194		
				Kronos Inc	Data Processing	1,898		
				Walnut Creek Management	Data Processing	1,500		
				PointClickCare Technologies	Data Processing	5,170		
				Various	Data Processing	137,755		
				Various	Professional Services	8,000		
				Allscripts Healthcare LLC	Professional Services	911		
				St. Andrews/Tutera	Management Fees	475,275		
TOTAL (agree to Schedule V, line 19, column 3)			\$ 749,935	TOTAL			\$	
(For legal fee disclosure, see page 39 of instructions)								

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number St. Paul's Home

0053629

Report Period Beginning: 1/1/2018

Ending: 12/31/2018

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 ?
- (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? 7
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 4,272 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. \$ 244,172
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? Yes Indicate the amount. \$ (4,084)
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 100%
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
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? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? No - IL costs still in overhead areas
- (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