

		FOR BHF USE					

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2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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

I. IDPH License ID Number: <u>0013920</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																																	
Facility Name: <u>ST PAULS HOME</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2012</u> to <u>12/31/2012</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. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																																																	
Address: <u>1021 WEST E STREET</u> <u>BELLEVILLE</u> <u>62220</u>																																																			
Number City Zip Code																																																			
County: <u>ST CLAIR</u>																																																			
Telephone Number: <u>(618) 223-2095</u> Fax # <u>(618) 233-2109</u>																																																			
HFS ID Number: _____																																																			
Date of Initial License for Current Owners: <u>UNABLE TO LOCATE</u>																																																			
Type of Ownership:																																																			
<table><tr><td>☐</td><td>VOLUNTARY,NON-PROFIT</td><td>☐</td><td>PROPRIETARY</td><td>☐</td><td>GOVERNMENTAL</td></tr><tr><td>☒</td><td>Charitable Corp.</td><td>☐</td><td>Individual</td><td>☐</td><td>State</td></tr><tr><td>☐</td><td>Trust</td><td>☐</td><td>Partnership</td><td>☐</td><td>County</td></tr><tr><td></td><td></td><td>☐</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td></td><td></td><td>☐</td><td>"Sub-S" Corp.</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Limited Liability Co.</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Trust</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Other _____</td><td></td><td></td></tr></table>		☐	VOLUNTARY,NON-PROFIT	☐	PROPRIETARY	☐	GOVERNMENTAL	☒	Charitable Corp.	☐	Individual	☐	State	☐	Trust	☐	Partnership	☐	County			☐	Corporation	☐	Other _____			☐	"Sub-S" Corp.					☐	Limited Liability Co.					☐	Trust					☐	Other _____				
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		☐	Limited Liability Co.																																																
		☐	Trust																																																
		☐	Other _____																																																
IRS Exemption Code _____																																																			
In the event there are further questions about this report, please contact:																																																			
Name: <u>KEVIN WELLEN</u>																																																			
Telephone Number: <u>(314) 231-5544</u>																																																			
Email Address: _____																																																			
		<table><tr><td rowspan="2">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Date) _____</td></tr><tr><td rowspan="5">Paid Preparer</td><td>(Type or Print Name) _____</td></tr><tr><td>(Title) _____</td></tr><tr><td>(Signed) _____</td></tr><tr><td>(Date) _____</td></tr><tr><td>(Print Name and Title) <u>KEVIN WELLEN</u> <u>SENIOR MANAGING CONSULTANT</u></td></tr><tr><td>(Firm Name & Address) <u>BKD, LLP</u> <u>211 N. BROADWAY, STE 600, ST. LOUIS, MO 63102</u></td><td></td></tr><tr><td>(Telephone) <u>(314) 231-5544</u> Fax # <u>(314) 231-9731</u></td><td></td></tr><tr><td colspan="2">MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001</td><td colspan="2">Phone # (217) 782-1630</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Date) _____	Paid Preparer	(Type or Print Name) _____	(Title) _____	(Signed) _____	(Date) _____	(Print Name and Title) <u>KEVIN WELLEN</u> <u>SENIOR MANAGING CONSULTANT</u>	(Firm Name & Address) <u>BKD, LLP</u> <u>211 N. BROADWAY, STE 600, ST. LOUIS, MO 63102</u>		(Telephone) <u>(314) 231-5544</u> Fax # <u>(314) 231-9731</u>		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																																
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Facility Name & ID Number ST PAULS HOME# 0013920 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	<u>76</u>	Skilled (SNF)	<u>76</u>	<u>27,816</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>39</u>	Intermediate (ICF)	<u>39</u>	<u>14,274</u>	3
4		Intermediate/DD			4
5	<u>60</u>	Sheltered Care (SC)	<u>60</u>	<u>21,960</u>	5
6		ICF/DD 16 or Less			6
7	175	TOTALS	175	64,050	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>12,576</u>	<u>9,354</u>	<u>3,095</u>	<u>25,025</u>	8
9	SNF/PED					9
10	ICF	<u>9,351</u>	<u>2,744</u>		<u>12,095</u>	10
11	ICF/DD					11
12	SC			<u>6,514</u>	<u>6,514</u>	12
13	DD 16 OR LESS					13
14	TOTALS	21,927	12,098	9,609	43,634	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 68.12%

D. How many bed-hold days during this year were paid by the Department?

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census?

YESG. 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 76 and days of care provided 3,095Medicare Intermediary NATIONAL GOVERNMENT SERVICES, INC.

IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH* ☐CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒NO ☐Tax Year: 12/31/2012 Fiscal Year: 12/31/2012

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	372,849	14,527	19,096	406,472		406,472	(7,841)	398,631			1
2	Food Purchase		286,904		286,904		286,904		286,904			2
3	Housekeeping	197,408	17,465	4,121	218,994		218,994		218,994			3
4	Laundry	107,328	4,039	4,812	116,179		116,179		116,179			4
5	Heat and Other Utilities			201,406	201,406		201,406		201,406			5
6	Maintenance	76,231	1,092	80,360	157,683		157,683		157,683			6
7	Other (specify):*											7
8	TOTAL General Services	753,816	324,027	309,795	1,387,638		1,387,638	(7,841)	1,379,797			8
	B. Health Care and Programs											
9	Medical Director			6,300	6,300		6,300		6,300			9
10	Nursing and Medical Records	2,096,937	90,253		2,187,190		2,187,190		2,187,190			10
10a	Therapy			511,868	511,868		511,868	(15)	511,853			10a
11	Activities	75,511	6,814		82,325		82,325		82,325			11
12	Social Services	32,562			32,562		32,562		32,562			12
13	CNA Training											13
14	Program Transportation	23,447			23,447		23,447		23,447			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,228,457	97,067	518,168	2,843,692		2,843,692	(15)	2,843,677			16
	C. General Administration											
17	Administrative	71,125		1,581	72,706	24,511	97,217		97,217			17
18	Directors Fees											18
19	Professional Services			480,420	480,420		480,420		480,420			19
20	Dues, Fees, Subscriptions & Promotions			55,730	55,730		55,730	(25,522)	30,208			20
21	Clerical & General Office Expenses	217,150	13,090	68,026	298,266	(24,511)	273,755	(21,851)	251,904			21
22	Employee Benefits & Payroll Taxes			664,959	664,959		664,959		664,959			22
23	Inservice Training & Education											23
24	Travel and Seminar			16,908	16,908		16,908		16,908			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			55,403	55,403		55,403		55,403			26
27	Other (specify):*											27
28	TOTAL General Administration	288,275	13,090	1,343,027	1,644,392		1,644,392	(47,373)	1,597,019			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,270,548	434,184	2,170,990	5,875,722		5,875,722	(55,229)	5,820,493			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			159,939	159,939		159,939		159,939			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			24,989	24,989		24,989	(945)	24,044			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			6,220	6,220		6,220		6,220			35
36	Other (specify):*											36
37	TOTAL Ownership			191,148	191,148		191,148	(945)	190,203			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			119,047	119,047		119,047		119,047			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			367,607	367,607		367,607		367,607			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			486,654	486,654		486,654		486,654			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,270,548	434,184	2,848,792	6,553,524		6,553,524	(56,174)	6,497,350			45

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

		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	(7,841)	1		4
5	Telephone, TV & Radio in Resident Rooms	(11,840)	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	(945)	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				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(25,522)	20		25
	Income Taxes and Illinois Personal				
26	Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(10,026)	21		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (56,174)		\$	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
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (56,174)		37

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

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

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

ST PAULS HOME

Report Period Beginning: ID# 0013920

Ending: 01/01/2012

12/31/2012

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	VENDING	\$ (2,324)	21	1
2	OTHER INCOME	(7,687)	21	2
3	EQUIPMENT RENTAL REVENUE	(15)	10a	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
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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	(10,026)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number ST PAULS HOME # 0013920 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	(7,841)	0	0	0	0	0	0	0	0	0	0	(7,841)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(7,841)	0	0	0	0	0	0	0	0	0	0	(7,841)	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	(15)	0	0	0	0	0	0	0	0	0	0	(15)	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	(15)	0	0	0	0	0	0	0	0	0	0	(15)	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	(25,522)	0	0	0	0	0	0	0	0	0	0	(25,522)	20
21	Clerical & General Office Expenses	(21,851)	0	0	0	0	0	0	0	0	0	0	(21,851)	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	(47,373)	0	0	0	0	0	0	0	0	0	0	(47,373)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(55,229)	0	0	0	0	0	0	0	0	0	0	(55,229)	29

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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(945)	0	0	0	0	0	0	0	0	0	0	(945)	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	(945)	0	0	0	0	0	0	0	0	0	0	(945)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(56,174)	0	0	0	0	0	0	0	0	0	0	(56,174)	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
N/A						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

YES

NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	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.

VII. RELATED PARTIES

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

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

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

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

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

Facility Name & ID Number ST PAULS HOME # 0013920 Report Period Beginning: 01/01/2012 Ending: 2/31/2012

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1	SOUTHWEST BANK		X	REAL ESTATE MORTGAGE	\$3,126.00	12/22/96	\$ 3,194,344	\$ 3,001,383	12/22/22	0.0704	\$ 24,989	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related				\$3,126.00		\$ 3,194,344	\$ 3,001,383			\$ 24,989	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 3,194,344	\$ 3,001,383			\$ 24,989	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 2011 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 2012 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:		2007		8	
		2008		9	
		2009		10	
		2010		11	
		2011		12	
				FOR BHF USE ONLY	
		13	FROM R. E. TAX STATEMENT FOR 2011	\$	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.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME
ST PAULS HOME

COUNTY
ST CLAIR

FACILITY IDPH LICENSE NUMBER
0013920

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ()
FAX #: ()

A.
Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2011 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 2011.

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

B.
Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home.
(Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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.**

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? ☒ (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).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ NO
If so, please complete the following:

1. Total Amount Incurred: _____

2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____

4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	RESIDENT USE	178,000	1926	\$ 16,901	1
2					2
3	TOTALS	178,000		\$ 16,901	3

Facility Name & ID Number ST PAULS HOME

0013920

Report Period Beginning:

01/01/2012

Ending:

12/31/2012

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			1960	1960	\$ 166,556	\$	25	\$	\$	\$ 166,556	4
5			1957	1957	148,250		50			148,250	5
6			1962	1962	266,677		50			266,677	6
7			1971	1971	654,498		40			654,498	7
8			1981	1981	718,104	16,833	40	16,833		569,407	8
	Improvement Type**										
9	1962 IMPROVEMENTS			1962	4,333		VARIOUS			4,333	9
10	1963 IMPROVEMENTS			1963	594		VARIOUS			594	10
11	1966 IMPROVEMENTS			1966	10,285		VARIOUS			10,285	11
12	1971 IMPROVEMENTS			1971	40,796		VARIOUS			40,796	12
13	1973 IMPROVEMENTS			1973	1,471		VARIOUS			1,471	13
14	1974 IMPROVEMENTS			1974	1,162		VARIOUS			1,162	14
15	1975 IMPROVEMENTS			1975	7,723		VARIOUS			7,723	15
16	1976 IMPROVEMENTS			1976	75,575		VARIOUS			75,575	16
17	1977 IMPROVEMENTS			1977	13,703		VARIOUS			13,703	17
18	1978 IMPROVEMENTS			1978	24,680		VARIOUS			24,680	18
19	1979 IMPROVEMENTS			1979	454,801		VARIOUS			454,801	19
20	1980 IMPROVEMENTS			1980	5,908		VARIOUS			5,908	20
21	1981 IMPROVEMENTS			1981			VARIOUS				21
22	1982 IMPROVEMENTS			1982	7,078		VARIOUS			7,078	22
23	1983 IMPROVEMENTS			1983	43,908		VARIOUS			43,908	23
24	1984 IMPROVEMENTS			1984	8,251		VARIOUS			8,251	24
25	1985 IMPROVEMENTS			1985	2,783		VARIOUS			2,783	25
26	1986 IMPROVEMENTS			1986	17,209		VARIOUS			17,209	26
27	1987 IMPROVEMENTS			1987	169,475	940	VARIOUS	940		155,454	27
28	1989 IMPROVEMENTS			1989	38,131		VARIOUS			38,131	28
29	1991 IMPROVEMENTS			1991	105,345	744	VARIOUS	744		103,113	29
30	1992 IMPROVEMENTS			1992	54,391		VARIOUS			54,391	30
31	1993 IMPROVEMENTS			1993	6,300	252	VARIOUS	252		5,040	31
32	1994 IMPROVEMENTS			1994	45,495		VARIOUS			45,495	32
33	1995 IMPROVEMENTS			1995	21,589		VARIOUS			21,589	33
34	1996 IMPROVEMENTS			1996	71,312	1,829	VARIOUS	1,829		65,825	34
35	1997 IMPROVEMENTS			1997	105,997	1,963	VARIOUS	1,963		94,994	35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number ST PAULS HOME

0013920

Report Period Beginning:

01/01/2012

Ending:

12/31/2012

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	1998 IMPROVEMENTS	1998	\$ 56,115	\$ 1,588	VARIOUS	\$ 1,588	\$	\$ 47,379	37
38	1999 IMPROVEMENTS	1999	24,704		VARIOUS			24,704	38
39	2000 IMPROVEMENTS	2000	29,955	1,336	VARIOUS	1,336		23,224	39
40	2001 IMPROVEMENTS	2001	62,410	2,208	VARIOUS	2,208		39,489	40
41	2002 IMPROVEMENTS	2002	89,661	3,000	VARIOUS	3,000		76,753	41
42	2003 IMPROVEMENTS	2003	31,961	3,089	VARIOUS	3,089		29,971	42
43	2004 IMPROVEMENTS	2004	58,035	4,107	VARIOUS	4,107		36,807	43
44	2005 IMPROVEMENTS	2005	74,581	7,458	VARIOUS	7,458		57,436	44
45									45
46	Repair bathroom ceiling lower roediger	2006	1,061	106	10	106		734	46
47	Architect services for Life Safety Code	2006	2,148	215	10	215		1,486	47
48	Furnish & install ductwork from grill to handler K-029	2006	2,168	217	10	217		1,481	48
49	Reception wired mirror replacement K-029	2006	800	80	10	80		540	49
50	Sprinkler head and drain K-056	2006	1,048	105	10	105		707	50
51	Install duct detcetor and modules K-067 and K-029	2006	1,560	156	10	156		1,053	51
52	Revision to UL 300 standards- Fire suppression system	2006	725	73	10	73		495	52
53	Architect services for Life Safety Code	2006	503	50	10	50		344	53
54	Install fire proofing in Roediger and Bartel- K025	2006	9,637	964	10	964		6,505	54
55	Revision to UL 300 standards- Fire suppression system	2006	721	72	10	72		487	55
56	Smoke detector replacement	2006	556		5			556	56
57	Architect services for Life Safety Code	2006	100	10	10	10		64	57
58	Generator tubing line- new install with labor	2006	652	65	10	65		429	58
59	New boiler system for Life Safety Code	2006	5,136	514	10	514		3,338	59
60	with tubing installation to lines for Life Safety Code	2006	6,246	625	10	625		4,060	60
61	Fron walk and railings- Life Safety Code	2006	25,913	2,591	10	2,591		16,843	61
62	Replacement compressors for HVAC	2006	4,597	460	10	460		2,950	62
63	Door replacements- Life Safety Code	2006	4,613	461	10	461		2,960	63
64	Boiler room door replacement for Life Safety Code	2006	6,517	652	10	652		4,127	64
65	22 fire dampers and 10 smoke detectors for Life Safety Code	2006	18,242	1,824	10	1,824		11,705	65
66	Life Safety Code for concrete ramp, pad and railings- EXIT	2006	4,597	460	10	460		2,835	66
67	Life Safety Code for fire duct detectors	2006	4,077	408	10	408		2,582	67
68	Final invoice on new boiler installment	2006	2,298	230	10	230		1,455	68
69	Architect for changes to ICF Wings	2006	2,500	250	10	250		1,521	69
70	TOTAL (lines 4 thru 69)		\$ 3,826,217	\$ 55,934		\$ 55,934	\$	\$ 3,514,702	70

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

Facility Name & ID Number ST PAULS HOME

0013920

Report Period Beginning:

01/01/2012 Ending: 12/31/2012

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,826,217	\$ 55,934		\$ 55,934	\$	\$ 3,514,702	1
2	Door replacement- kitchen doors	2006	963	96	10	96		634	2
3	Door replacement- back doors	2006	589	59	10	59		388	3
4	Wall guards for resident assistance	2007	850	85	10	85		482	4
5	Fire sprinkler enhancements	2007	994	99	10	99		563	5
6	New kitchen plumbing lines	2007	7,479	748	10	748		4,238	6
7	Cooling tower replacement- 2 amts	2007	995	99	10	99		547	7
8	Install blower and MotorHVAC	2007	1,513	76	20	76		416	8
9	Medicare wing architects	2008	3,454	173	20	173		792	9
10	Medicare wing architects	2008	5,096	255	20	255		1,168	10
11	Medicare wing architects- 2 inv.	2008	2,664	133	20	133		611	11
12	Medicare wing architects	2008	4,543	227	20	227		1,041	12
13	Medicare wing architects	2008	18,255	913	20	913		4,183	13
14	Medicare wing architects	2008	2,700	135	20	135		619	14
15	Medicare wing architects 2 inv.	2008	1,272	64	20	64		292	15
16	Medicare wing architects	2008	4,394	220	20	220		1,007	16
17	Medicare wing- Roediger metal doors	2008	4,048	202	20	202		928	17
18	Medicare wing architects- 2 inv.	2008	1,288	64	20	64		295	18
19	Medicare wing architects	2008	320	16	20	16		73	19
20	Medicare wing- crawl space abatement	2008	856	43	20	43		196	20
21	Medicare wing- Roediger fireproofing	2008	18,661	933	20	933		4,276	21
22	Medicare wing architects	2008	1,292	65	20	65		296	22
23	Medicare wing architects	2008	5,586	279	20	279		1,280	23
24	Medicare wing- Roediger fireproofing	2008	50,455	2,523	20	2,523		11,563	24
25	Medicare wing- construction	2008	68,205	3,410	20	3,410		15,630	25
26	Medicare wing architects	2008	3,277	164	20	164		751	26
27	5 ton, 3 stage AC	2008	5,036	504	10	504		2,308	27
28	Medicare wing- construction	2008	68,883	3,444	20	3,444		15,786	28
29	Medicare wing architects	2008	1,380	69	20	69		316	29
30	Medicare wing construction staffing	2008	768	38	10	38		176	30
31	Moved Pneumatic Thermostats	2008	552	55	10	55		253	31
32	Medicare wing architects	2008	8,251	413	20	413		1,891	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,120,836	\$ 71,539		\$ 71,539	\$	\$ 3,587,700	34

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

Facility Name & ID Number ST PAULS HOME

0013920

Report Period Beginning:

01/01/2012 Ending: 12/31/2012

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	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 4,120,836	\$ 71,539		\$ 71,539	\$	\$ 3,587,700	1
2	Medicare wing architects	2008	564	28	20	28		129	2
3	Medicare wing construction	2008	1,735	87	20	87		398	3
4	Medicare wing construction	2008	920	46	20	46		211	4
5	Medicare wing construction	2008	47,296	2,365	20	2,365		10,839	5
6	Rehab unit	2008	4,249	212	20	212		938	6
7	Kitchenette** see below itemization	2008	6,350	635	10	635		2,752	7
8	Concrete work, steps, ramp NRSRG	2008	10,250	513	20	513		2,264	8
9	Rehab unit, nursing, common areas	2008	30,000	1,500	20	1,500		6,375	9
10	Railings for Nursin g home	2008	3,150	158	20	158		656	10
11	Kitchenette** see below itemization	2008	1,666	167	10	167		680	11
12	Roediger railings, steam tables	2009	1,971	394	5	394		1,544	12
13	Dietary steam table set up	2009	842	168	5	168		646	13
14	Door replacement, back entrance	2009	1,070	107	10	107		392	14
15	Parking lot	2009	2,840	284	10	284		970	15
16	Air conditioning units- 3	2009	1,335	267	5	267		912	16
17	Soffit and Fascia- home building	2009	27,044	1,352	20	1,352		4,507	17
18	Soffit and Fascia- home building	2009	590	118	5	118		384	18
19	Rooftop condensor unit- HVAC	2009	11,190	1,119	10	1,119		3,637	19
20	Butterfly valve for HVAC	2009	1,471	147	10	147		478	20
21	Dining room Bartel	2009	770	77	10	77		231	21
22	Carpet 3600 sq ft dining room	2009	12,010	1,201	10	1,201		3,603	22
23	Dining room Bartel	2009	1,425	143	10	143		428	23
24	Dining room Bartel	2009	2,360	236	10	236		708	24
25	Dining room improvements for SNF Bartel	2010	1,791	179	10	179		522	25
26	Dining room improvements for SNF Bartel	2010	230	23	10	23		59	26
27	25 ton air condensing unit in Chapel area	2010	18,538	927	20	927		2,472	27
28	Fire sprinkler move for hallway/storage room	2010	1,960	196	10	196		523	28
29	Outside and Inside back door	2010	5,845	585	10	585		1,510	29
30	Draperies for dining room improvement for SNF Bartel	2010	1,443	144	10	144		373	30
31	Dining room improvements for SNF Bartel	2010	5,977	598	10	598		1,395	31
32	Dining room improvements for SNF Bartel	2010	464	46	10	46		93	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,328,182	\$ 85,561		\$ 85,561	\$	\$ 3,638,328	34

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

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

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 2,071,886	\$ 62,346	\$ 62,346	\$		\$ 1,748,188	71
72	Current Year Purchases	26,955	2,925	2,925			2,925	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 2,098,841	\$ 65,271	\$ 65,271	\$		\$ 1,751,113	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	VAN	FORD ECOLINE 1992	1993	\$ 550	\$	\$	\$		\$ 550	76
77	VAN IMPROVEMENTS	ECONOLINE VAN/LIFT 1992	95, '96, '97	18,395					18,395	77
78	PATIENT TRANSPORT	BUICK LESABRE 1995	2009	15,329	2,190	2,190			6,570	78
79	PATIENT TRANSPORT	CHEVY IMPALA 2006	2009	16,505	2,358	2,358			7,073	79
80	TOTALS			\$ 50,779	\$ 4,548	\$ 4,548	\$		\$ 32,588	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 6,585,472	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 159,943	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 159,943	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)	\$ 5,427,990	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	CATAWBA Bldg & Land	\$ 244,051	\$ 3,510	\$ 90,927	86
87	APARTMENT LAND	83,097			87
88	APARTMENT BUILDING	5,378,982	136,308	2,972,691	88
89	APARTMENT EQUIP & COMP	272,624	5,382	249,742	89
90	APARTMENT VEHICLES	34,262		34,262	90
91	TOTALS	\$ 6,013,016	\$ 145,200	\$ 3,347,622	91

G. Construction-in-Progress

	Description	Cost	
92	New Building for 2015	\$ 362,148	92
93			93
94			94
95		\$ 362,148	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.

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

**

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: \$6,220
- 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

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.	/2013	\$
13.	/2014	\$
14.	/2015	\$

* 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.

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
☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM☐
IN OTHER FACILITY☐
COMMUNITY COLLEGE☐
HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM☐
IN OTHER FACILITY☐
HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		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		hrs	\$	2,638	\$ 172,055	\$	2,638	\$ 172,055	1
2	Licensed Speech and Language Development Therapist		hrs		1,610	120,182		1,610	120,182	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs		3,082	219,631		3,082	219,631	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$	7,330	\$ 511,868	\$	7,330	\$ 511,868	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.

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	\$ 1,179,288	\$	1
2	Cash-Patient Deposits	8,645		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 90,000)	1,564,019		3
4	Supply Inventory (priced at)	43,525		4
5	Short-Term Investments			5
6	Prepaid Insurance	110,124		6
7	Other Prepaid Expenses	17,925		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Stancorp Assets</u>	9,665		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,933,191	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	22,696		13
14	Buildings, at Historical Cost	3,918,855		14
15	Leasehold Improvements, at Historical Cost	862,245		15
16	Equipment, at Historical Cost	2,149,620		16
17	Accumulated Depreciation (book methods)	(5,427,989)		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): <u>ASSISTED LIVING</u>	2,665,394		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 4,190,821	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 7,124,012	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 511,602	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	24,234		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	164,576		30
31	Accrued Taxes Payable (excluding real estate taxes)	12,619		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation	5,440		34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 718,471	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	3,113,108		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>ASSISTED LIVING</u>	5,153		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 3,118,261	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,836,732	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,287,280	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 7,124,012	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,595,679	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,595,679	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	691,601	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)	\$ 691,601	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)	\$ 3,287,280	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number **ST PAULS HOME**# **0013920**Report Period Beginning: **01/01/2012**Ending: **12/31/2012**

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		2
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 5,457,891	1
2	Discounts and Allowances for all Levels	(579,299)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,878,592	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,352,165	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,352,165	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	7,841	14
15	Telephone, Television and Radio	11,840	15
16	Rental of Facility Space		16
17	Sale of Drugs	64,714	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	3,339	19
20	Radiology and X-Ray	8,911	20
21	Other Medical Services	556,183	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 652,828	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	945	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 945	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	OTHER INCOM	92,563	28
28a	ASSISTED LIVING INCOME	268,032	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 360,595	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,245,125	30

	1		2
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,387,638	31
32	Health Care	2,843,692	32
33	General Administration	1,644,392	33
	B. Capital Expense		
34	Ownership	191,148	34
	C. Ancillary Expense		
35	Special Cost Centers	119,047	35
36	Provider Participation Fee	367,607	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,553,524	40
41	Income before Income Taxes (line 30 minus line 40)**	691,601	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 691,601	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 2,430,936	44
45	Private Pay - Net Inpatient Revenue	401,012	45
46	Medicare - Net Inpatient Revenue	2,046,644	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,878,592	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.

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,088	2,088	\$ 67,310	\$ 32.24	1
2	Assistant Director of Nursing	2,088	2,088	62,218	29.80	2
3	Registered Nurses	6,915	6,915	169,295	24.48	3
4	Licensed Practical Nurses	31,187	31,187	609,601	19.55	4
5	CNAs & Orderlies	98,641	98,641	1,089,458	11.04	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	7,375	7,375	75,511	10.24	10
11	Social Service Workers	2,088	2,088	32,562	15.59	11
12	Dietician	34,144	34,144	372,849	10.92	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	7,712	7,712	99,678	12.93	17
18	Housekeepers	18,524	18,524	197,408	10.66	18
19	Laundry	11,419	11,419	107,328	9.40	19
20	Administrator	2,088	2,088	71,125	34.06	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	13,446	13,446	217,150	16.15	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	2,002	2,002	27,270	13.62	31
32	Other Health Care MDS COORDINATOR	2,088	2,088	55,132	26.40	32
33	Other(specify) CENTRAL SUPPLY	1,888	1,888	16,653	8.82	33
34	TOTAL (lines 1 - 33)	243,693	243,693	\$ 3,270,548 *	\$ 13.42	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director		6,300	9	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 6,300		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

[illegible]

*** Attach copy of IMRF notifications**

****See instructions.**

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

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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.

\$6,457- LSN IL ASSOC- NURSING HOME
- (3)

Did the nursing home make political contributions or payments to a political action organization?

NO

If YES, have these costs been properly adjusted out of the cost report?
- (4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?

NO

If YES, what is the capacity?
- (5)

Have you properly capitalized all major repairs and equipment purchases?

YES

What was the average life used for new equipment added during this period?

YES
- (6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$

34,878

Line
- (7)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

YES

If NO, attach a complete explanation.
- (8)

Are you presently operating under a sale and leaseback arrangement?

NO

If YES, give effective date of lease.
- (9)

Are you presently operating under a sublease agreement?

YES

X

NO
- (10)

Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?

YES

NO

X

If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
- (11)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$

367,607

This amount is to be recorded on line 42 of Schedule V.
- (12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?

NO

If YES, attach an explanation of the allocation.

- (13)

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

YES
- (14)

Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?

NO

For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.

\$

NONE

Has any meal income been offset against related costs?

NO

Indicate the amount.

\$
- (16)

Travel and Transportation

a. Are there costs included for out-of-state travel?

NO

If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents?

NO

If YES, please indicate the amount of income earned from such a program during this reporting period.

\$

c. What percent of all travel expense relates to transportation of nurses and patients?

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?

NO

g. Does the facility transport residents to and from day training?

NO

Indicate the amount of income earned from providing such transportation during this reporting period.

\$
- (17)

Has an audit been performed by an independent certified public accounting firm?

YES

Firm Name:

BKD, LLP
- (18)

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

YES
- (19)

If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report?

YES

Attach invoices and a summary of services for all architect and appraisal fees.