

		FOR BHF USE					

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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>0053629</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>1/01/2016</u> to <u>12/31/2016</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>618-233-2095</u> Fax # <u>618-233-2109</u>																																																																																					
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) _____</td></tr><tr><td>(Title) _____</td></tr><tr><td>(Signed) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Print Name and Title) <u>Kevin Wellen, CPA</u></td></tr><tr><td>(Firm Name & Address) <u>Director</u></td></tr><tr><td><u>CliftonLarsonAllen, LLP</u></td></tr><tr><td><u>600 Washington Ave. Suite 1800, St. Louis, MO 63101</u></td></tr><tr><td colspan="2">Date of Initial License for Current Owners: <u>Unable to Locate</u></td><td colspan="2">(Telephone) <u>314-925-4446</u> Fax # <u>314-925-4350</u></td></tr><tr><td colspan="2">Type of Ownership:</td><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 Phone # (217) 782-1630</td></tr><tr><td colspan="2"><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 colspan="2">IRS Exemption Code <u>501(c)3</u></td><td>☐</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td colspan="2"></td><td>☐</td><td>"Sub-S" Corp.</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td>☐</td><td>Limited Liability Co.</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td>☐</td><td>Trust</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td>☐</td><td>Other _____</td><td colspan="2">_____</td></tr></table></td><td colspan="2"></td></tr><tr><td colspan="2">In the event there are further questions about this report, please contact:</td><td colspan="2"></td></tr><tr><td colspan="2">Name: <u>Kevin Wellen</u></td><td colspan="2">Telephone Number: <u>314-925-4446</u></td></tr><tr><td colspan="2">Email Address: _____</td><td colspan="2">_____</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____	(Title) _____	(Signed) _____	Paid Preparer	(Print Name and Title) <u>Kevin Wellen, CPA</u>	(Firm Name & Address) <u>Director</u>	<u>CliftonLarsonAllen, LLP</u>	<u>600 Washington Ave. Suite 1800, St. Louis, MO 63101</u>	Date of Initial License for Current Owners: <u>Unable to Locate</u>		(Telephone) <u>314-925-4446</u> Fax # <u>314-925-4350</u>		Type of Ownership:		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		<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 colspan="2">IRS Exemption Code <u>501(c)3</u></td><td>☐</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td colspan="2"></td><td>☐</td><td>"Sub-S" Corp.</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td>☐</td><td>Limited Liability Co.</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td>☐</td><td>Trust</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td>☐</td><td>Other _____</td><td colspan="2">_____</td></tr></table>		☒	VOLUNTARY, NON-PROFIT	☐	PROPRIETARY	☐	GOVERNMENTAL	☒	Charitable Corp.	☐	Individual	☐	State	☐	Trust	☐	Partnership	☐	County	IRS Exemption Code <u>501(c)3</u>		☐	Corporation	☐	Other _____			☐	"Sub-S" Corp.	_____				☐	Limited Liability Co.	_____				☐	Trust	_____				☐	Other _____	_____				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: _____		_____	
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Facility Name & ID Number St Pauls Home

0053629 Report Period Beginning: 1/01/2016 Ending: 12/31/2016

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>90</u>	Skilled (SNF)	<u>90</u>	<u>32,940</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>18</u>	Intermediate (ICF)	<u>18</u>	<u>6,588</u>	3
4		Intermediate/DD			4
5	<u>26</u>	Sheltered Care (SC)	<u>26</u>	<u>9,516</u>	5
6		ICF/DD 16 or Less			6
7	<u>134</u>	TOTALS	<u>134</u>	<u>49,044</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>9,873</u>	<u>12,604</u>	<u>4,917</u>	<u>27,394</u>	8
9	SNF/PED					9
10	ICF	<u>985</u>	<u>3,542</u>		<u>4,527</u>	10
11	ICF/DD					11
12	SC		<u>4,572</u>		<u>4,572</u>	12
13	DD 16 OR LESS					13
14	TOTALS	<u>10,858</u>	<u>20,718</u>	<u>4,917</u>	<u>36,493</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.41%

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

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy) Outpatient therapy 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 4,917

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: 12/31/2016 Fiscal Year: 12/31/2016

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

Facility Name & ID Number St Pauls Home # 0053629 Report Period Beginning: 1/01/2016 Ending: 12/31/2016

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	532,914	21,670	10,328	564,912		564,912	(6,694)	558,218			1
2	Food Purchase		266,465		266,465		266,465		266,465			2
3	Housekeeping	99,084	21,500		120,584		120,584		120,584			3
4	Laundry	73,633	12,667		86,300		86,300		86,300			4
5	Heat and Other Utilities			174,106	174,106		174,106		174,106			5
6	Maintenance	65,513	1,432	49,077	116,022		116,022		116,022			6
7	Other (specify):* Trash			8,932	8,932		8,932		8,932			7
8	TOTAL General Services	771,144	323,734	242,443	1,337,321		1,337,321	(6,694)	1,330,627			8
	B. Health Care and Programs											
9	Medical Director			10,800	10,800		10,800		10,800			9
10	Nursing and Medical Records	2,759,871	36,179	89,575	2,885,625		2,885,625	(197,585)	2,688,040			10
10a	Therapy											10a
11	Activities	72,564	8,787	2,644	83,995		83,995		83,995			11
12	Social Services	46,195			46,195		46,195		46,195			12
13	CNA Training											13
14	Program Transportation	29,161		1,917	31,078		31,078		31,078			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,907,791	44,966	104,936	3,057,693		3,057,693	(197,585)	2,860,108			16
	C. General Administration											
17	Administrative	98,098			98,098		98,098		98,098			17
18	Directors Fees											18
19	Professional Services			661,768	661,768		661,768		661,768			19
20	Dues, Fees, Subscriptions & Promotions			94,988	94,988		94,988	(65,707)	29,281			20
21	Clerical & General Office Expenses	281,277	25,095	595,473	901,845		901,845	(548,092)	353,753			21
22	Employee Benefits & Payroll Taxes			924,315	924,315		924,315		924,315			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,269	4,269		4,269		4,269			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			93,489	93,489		93,489		93,489			26
27	Other (specify):*											27
28	TOTAL General Administration	379,375	25,095	2,374,302	2,778,772		2,778,772	(613,799)	2,164,973			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,058,310	393,795	2,721,681	7,173,786		7,173,786	(818,078)	6,355,708			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			1,022,318	1,022,318		1,022,318		1,022,318			30
31	Amortization of Pre-Op. & Org.			189,661	189,661		189,661		189,661			31
32	Interest			1,156,336	1,156,336		1,156,336	(138)	1,156,198			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			10,955	10,955		10,955		10,955			35
36	Other (specify):*											36
37	TOTAL Ownership			2,379,270	2,379,270		2,379,270	(138)	2,379,132			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		240,772	753,823	994,595		994,595		994,595			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			221,314	221,314		221,314		221,314			42
43	Other (specify):* Assisted Living	284,561	12,742	913,652	1,210,955		1,210,955	(1,210,955)				43
44	TOTAL Special Cost Centers	284,561	253,514	1,888,789	2,426,864		2,426,864	(1,210,955)	1,215,909			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,342,871	647,309	6,989,740	11,979,920		11,979,920	(2,029,171)	9,950,749			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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(6,694)	1		4
5	Telephone, TV & Radio in Resident Rooms	(24,713)	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	(138)	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	(27,078)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(495,038)	21		24
25	Fund Raising, Advertising and Promotional	(65,707)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See PG5A	(1,409,803)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (2,029,171)		\$	30

BHF USE ONLY								
48		49		50		51		52

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (2,029,171)		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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Vending Income	\$ (1,263)	21	1
2	Other Income	(197,585)	10	2
3	Assisted Living Expenses	(1,210,955)	43	3
4				4
5				5
6				6
7				7
8				8
9				9
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42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(1,409,803)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number St Pauls Home # 0053629 Report Period Beginning: 1/01/2016 Ending: 12/31/2016

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	(6,694)	0	0	0	0	0	0	0	0	0	0	(6,694)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(6,694)	0	0	0	0	0	0	0	0	0	0	(6,694)	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	(197,585)	0	0	0	0	0	0	0	0	0	0	(197,585)	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	(197,585)	0	0	0	0	0	0	0	0	0	0	(197,585)	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	(65,707)	0	0	0	0	0	0	0	0	0	0	(65,707)	20
21	Clerical & General Office Expenses	(548,092)	0	0	0	0	0	0	0	0	0	0	(548,092)	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	(613,799)	0	0	0	0	0	0	0	0	0	0	(613,799)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(818,078)	0	0	0	0	0	0	0	0	0	0	(818,078)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number St Pauls Home # 0053629 Report Period Beginning: 1/01/2016 Ending: 12/31/2016

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	(138)	0	0	0	0	0	0	0	0	0	0	(138)	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	(138)	0	0	0	0	0	0	0	0	0	0	(138)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(1,210,955)	0	0	0	0	0	0	0	0	0	0	(1,210,955)	43
44	TOTAL Special Cost Centers	(1,210,955)	0	0	0	0	0	0	0	0	0	0	(1,210,955)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(2,029,171)	0	0	0	0	0	0	0	0	0	0	(2,029,171)	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 Schedule V		2 Line	3 Cost Per General Ledger	4 Amount	5 Cost to Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
			Item		Name 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 Pauls Home

0053629

Report Period Beginning:

1/01/2016

Ending:

12/31/2016

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	Steve Suess	BOD						1
2	Kristine Mueller	BOD						2
3	Beverly Brightwell	BOD						3
4	Betty Leppard	BOD						4
5	Rev. Andrew Kramer	BOD						5
6	Al Scharf	BOD						6
7	Jason Karstens	BOD						7
8	Bob DeCamp	BOD						8
9	Craig Brethauer	BOD						9
10	Margaret Lowery	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 Pauls Home # 0053629 Report Period Beginning: 1/01/2016 Ending: 12/31/2016

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 Pauls Home # 0053629 Report Period Beginning: 1/01/2016 Ending: 2/31/2016

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	First Bank		X	Note Payable Term Loans	varies	12/10/13	\$ 21,600,000	\$ 21,150,069	6/10/19	0.0500	\$ 803,797	1	
2	The Good Samaritan Independent Liv		X	Subordinated Loan Payable	varies	12/10/13	3,500,000	4,107,093	12/10/26	0.0700	246,777	2	
3	St. Andrew's Resources for Seniors		X	Subordinated Loan Payable	varies	12/10/13	1,500,000	1,760,183	12/10/26	0.0700	105,762	3	
4	Interest Income										(138)	4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$ 26,600,000	\$ 27,017,345			\$ 1,156,198	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	\$ 27,017,345			\$ 1,156,198	15	

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

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

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

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 2015 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 2016 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:		2011		8	
		2012		9	
		2013		10	
		2014		11	
		2015		12	
				FOR BHF USE ONLY	
		13	FROM R. E. TAX STATEMENT FOR 2015	\$	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.

FACILITY NAME	St Pauls Home	COUNTY	St Clair
---------------	---------------	--------	----------

CONTACT PERSON REGARDING THIS REPORT _____

A. Summary of Real Estate Tax Cost

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

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

C. Tax Bills

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.**

A. Square Feet: 90,492

B. General Construction Type: Exterior Brick, VinylFrameNumber 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).
St. Paul's Home consists of 90 skilled beds, 26 shelter beds, 18 memory care beds, and 53 apartments.

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES

☒ 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	\$ 22,696	1
2					2
3	TOTALS	178,000		\$ 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	\$ 438,805	40	\$ 438,805	\$	\$ 622,819
5										
6										
7										
8										
	Improvement Type**									
9	1981 IMPROVEMENTS			1981	10,965		15			10,965
10	1982 IMPROVEMENTS			1982	3,200		15			3,200
11	1983 IMPROVEMENTS			1983	4,380		15			4,380
12	1987 IMPROVEMENTS			1987	112,643		VARIOUS			112,643
13	1996 IMPROVEMENTS			1996	19,617		VARIOUS			19,617
14	1997 IMPROVEMENTS			1997	12,290		VARIOUS			12,290
15	SNF Building - Tools & Equipment			2015	15,473	2,210	7	2,210		3,131
16	SNF Building - Asphalt Paving			2015	167,386	20,923	8	20,923		29,641
17	SNF Building - Landscaping and Irrigation			2015	209,910	20,991	10	20,991		29,737
18	SNF Building - Carpentry			2015	273,402	18,227	15	18,227		25,822
19	SNF Building - General Door Openings			2015	754,955	37,748	20	37,748		53,476
20	SNF Building - Automatic Doors & Operators			2015	11,666	1,167	10	1,167		1,653
21	SNF Building - Ceramic Tile			2015	299,865	14,993	20	14,993		21,240
22	SNF Building - Flooring			2015	368,589	18,429	20	18,429		26,108
23	SNF Building - Painting & Wallcovering			2015	298,517	59,703	5	59,703		84,579
24	SNF Building - Residential Appliances			2015	136,074	13,607	10	13,607		19,277
25	SNF Building - Commercial Laundry Equipment			2015	51,208	3,414	15	3,414		4,836
26	SNF Building - HVAC			2015	1,710,935	85,547	20	85,547		121,191
27	SNF Building - Plumbing			2015	1,345,918	67,296	20	67,296		95,336
28	Costs of Issuance (Construction Draws)			2015	273,314	6,833	40	6,833		9,680
29										
30										
31										
32										
33										
34										
35										
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

0053629

Report Period Beginning:

1/01/2016

Ending:

12/31/2016

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	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	\$ 809,894		\$ 809,894	\$	\$ 1,311,622	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	\$ 1,464,199	\$ 201,395	\$ 201,395	\$		\$ 440,770	71
72	Current Year Purchases	46,518						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,510,717	\$ 201,395	\$ 201,395	\$		\$ 440,770	75

D. Vehicle Costs. (See instructions.)*									
	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9
76	Van	Ford Econoline 1992	1993	\$ 550	\$	\$	\$		\$ 550
77	Van Improvements	Econoline Van Life '92	'95, '96, '97	18,395					18,395
78	Patient Transport	95 LeSabre & '06 Impala	2009	31,834	9,094	9,094		7	31,834
79	Patient Transport	2007 Van	2016	32,500	1,935	1,935		7	1,935
80	TOTALS			\$ 83,279	\$ 11,029	\$ 11,029	\$		\$ 52,714

E. Summary of Care-Related Assets					1	2
		Reference			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)			\$	25,756,736
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	1,022,318
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	1,022,318
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	1,805,106

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	\$	\$
87	Apartment Building	5,751,008	144,618	3,511,109
88	Apartment Equip & Comp	282,466	4,363	268,091
89	Apartment Vehicles	34,262		34,262
90				
91	TOTALS	\$ 6,150,833	\$ 148,981	\$ 3,813,462

G. Construction-in-Progress		
	Description	Cost
92		\$
93		
94		
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

XNO

		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

XNO
16. Rental Amount for movable equipment: \$10,955

Description: Copier

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

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)	\$			

(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.

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	

(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	V39-3	hrs	\$	4,650	\$ 227,220	\$	4,650	\$ 227,220	1
2	Licensed Speech and Language Development Therapist	V39-3	hrs		3,525	182,261		3,525	182,261	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	V39-3	hrs		6,485	277,097		6,485	277,097	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			\$	14,660	\$ 686,578	\$	14,660	\$ 686,578	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	\$ 826,941	\$	1
2	Cash-Patient Deposits	17,234		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 533,583)	1,846,818		3
4	Supply Inventory (priced at)	18,954		4
5	Short-Term Investments	30,183		5
6	Prepaid Insurance	103,093		6
7	Other Prepaid Expenses	22,103		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Other Current Assets	453,242		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,318,568	\$	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	23,976,949		14
15	Leasehold Improvements, at Historical Cost	163,095		15
16	Equipment, at Historical Cost	1,593,996		16
17	Accumulated Depreciation (book methods)	(1,805,106)		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): Assisted Living	2,337,371		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 26,289,001	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 29,607,569	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 713,232	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	46,719		28
29	Short-Term Notes Payable	1,129,913		29
30	Accrued Salaries Payable	113,043		30
31	Accrued Taxes Payable (excluding real estate taxes)	6,804		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	300,228		33
34	Deferred Compensation			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)	\$ 2,309,939	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	25,969,065		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Assisted Living	54,481		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 26,023,546	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 28,333,485	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,274,084	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 29,607,569	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,624,656	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,624,656	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,350,572)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (1,350,572)	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)	\$ 1,274,084	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number St Pauls Home

0053629

Report Period Beginning: 1/01/2016

Ending: 12/31/2016

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	\$ 8,997,694	1
2	Discounts and Allowances for all Levels	(2,067,629)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,930,065	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,843,705	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,843,705	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	6,694	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients	152,882	18
19	Laboratory	3,236	19
20	Radiology and X-Ray	7,641	20
21	Other Medical Services	37,872	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 208,325	23
	D. Non-Operating Revenue		
24	Contributions	120,000	24
25	Interest and Other Investment Income***	257	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 120,257	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Other Revenue/Losses</u>	198,848	28
28a	<u>AL Revenue</u>	1,328,148	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,526,996	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,629,348	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,337,321	31
32	Health Care	3,057,693	32
33	General Administration	2,778,772	33
	B. Capital Expense		
34	Ownership	2,379,270	34
	C. Ancillary Expense		
35	Special Cost Centers	2,205,550	35
36	Provider Participation Fee	221,314	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 11,979,920	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,350,572)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,350,572)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 1,278,310	44
45	Private Pay - Net Inpatient Revenue	4,853,746	45
46	Medicare - Net Inpatient Revenue	843,676	46
47	Other-(specify) <u>Charity Write-Offs</u>	(19,327)	47
48	Other-(specify) <u>New Bldg Discount</u>	(26,340)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 6,930,065	49

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

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

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

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

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	\$ 83,520	\$ 40.00	1
2	Assistant Director of Nursing	2,088	2,088	52,200	25.00	2
3	Registered Nurses	9,223	9,223	348,884	37.83	3
4	Licensed Practical Nurses	39,078	39,078	839,426	21.48	4
5	CNAs & Orderlies	111,843	111,843	1,386,087	12.39	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	6,706	6,706	72,564	10.82	10
11	Social Service Workers	2,088	2,088	46,195	22.12	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	50,153	50,153	421,916	8.41	15
16	Dishwashers					16
17	Maintenance Workers	9,907	9,907	96,584	9.75	17
18	Housekeepers	8,527	8,527	99,084	11.62	18
19	Laundry	6,775	6,775	73,633	10.87	19
20	Administrator	2,088	2,088	98,098	46.98	20
21	Assistant Administrator					21
22	Other Administrative	14,805	14,805	315,947	21.34	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	4,076	4,076	40,760	10.00	31
32	Other Health Care MDS Coordinator	2,979	2,979	83,412	28.00	32
33	Other(specify) Assisted Living	21,175	21,175	284,561	13.44	33
34	TOTAL (lines 1 - 33)	293,599	293,599	\$ 4,342,871 *	\$ 14.79	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	222	\$ 10,328	1-3	35
36	Medical Director	Monthly	10,800	9-3	36
37	Medical Records Consultant	35	1,983	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	6,485	277,997	39-3	40
41	Occupational Therapy Consultant	4,650	227,220	39-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	3,525	182,261	39-3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	14,916	\$ 710,589		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

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?
If YES, give association name and amount.

Yes

Leading Age - \$7,094

(3)

Did the nursing home make political contributions or payments to a political action organization?
If YES, have these costs been properly adjusted out of the cost report?

No

N/A

(4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?
If YES, what is the capacity?

No

N/A

(5)

Have you properly capitalized all major repairs and equipment purchases?
What was the average life used for new equipment added during this period?

Yes

7 yrs

(6)

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

\$

34,740

Line

10

(7)

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

Yes

(8)

Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease.

No

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

X

N/A

(11)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.
This amount is to be recorded on line 42 of Schedule V.

\$

221,314

(12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?
If YES, attach an explanation of the allocation.

No

(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?
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.

No

(15)

Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V.
Has any meal income been offset against related costs?

\$

0

No

Indicate the amount.

\$

0

(16)

Travel and Transportation

a.

Are there costs included for out-of-state travel?
If YES, attach a complete explanation.

No

b.

Do you have a separate contract with the Department to provide medical transportation for residents?
If YES, please indicate the amount of income earned from such a program during this reporting period.

No

N/A

c.

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

0

d.

Have vehicle usage logs been maintained?

Yes

e.

Are all vehicles stored at the nursing home during the night and all other times when not in use?

Yes

f.

Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

Yes

g.

Does the facility transport residents to and from day training?
Indicate the amount of income earned from providing such transportation during this reporting period.

No

N/A

(17)

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

Yes

CliftonLarsonAllen LLP

(18)

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

Yes

(19)

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

Yes