

		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: 0005165 Facility Name: St Pauls House & Hlth Cr Ctr Address: 3800 N California Av Chicago 60618 County: Cook Telephone Number: (773) 478-4222 Fax # (773)478-4516 HFS ID Number: Date of Initial License for Current Owners: 01/10/24 Type of Ownership: ☒ VOLUNTARY,NON-PROFIT ☒ Charitable Corp. ☐ Trust IRS Exemption Code ☐ PROPRIETARY ☐ Individual ☐ Partnership ☐ Corporation ☐ "Sub-S" Corp. ☐ Limited Liability Co. ☐ Trust ☐ Other ☐ GOVERNMENTAL ☐ State ☐ County ☐ Other

In the event there are further questions about this report, please contact:

Name: Deb Freeland

Telephone Number: 317-574-9100

Email Address:

Facility Name & ID Number St Pauls House & Hlth Cr Ctr

0005165 Report Period Beginning: 7/01/2015 Ending: 6/30/2016

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>110</u>	Skilled (SNF)	<u>110</u>	<u>40,260</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	<u>61</u>	Sheltered Care (SC)	<u>61</u>	<u>22,326</u>	5
6		ICF/DD 16 or Less			6
7	<u>171</u>	TOTALS	<u>171</u>	<u>62,586</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>8,872</u>	<u>8,647</u>	<u>11,411</u>	<u>28,930</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC		<u>15,835</u>		<u>15,835</u>	12
13	DD 16 OR LESS					13
14	TOTALS	<u>8,872</u>	<u>24,482</u>	<u>11,411</u>	<u>44,765</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 71.53%

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

None (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)

Meals on wheels, outpatient therapy

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 11/24/1974

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 110 and days of care provided 11,411

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: 6/30/2016 Fiscal Year: 6/30/2016

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

Facility Name & ID Number St Pauls House & Hlth Cr Ctr # 0005165 Report Period Beginning: 7/01/2015 Ending: 6/30/2016

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	617,603		65,869	683,472		683,472		683,472			1
2	Food Purchase		398,927		398,927		398,927	(46,529)	352,398			2
3	Housekeeping	256,180	53,103	2,559	311,842		311,842		311,842			3
4	Laundry	60,767	7,620	8,693	77,080		77,080		77,080			4
5	Heat and Other Utilities			319,135	319,135		319,135		319,135			5
6	Maintenance	197,819	41,000	282,320	521,139		521,139		521,139			6
7	Other (specify):* Security	60,894	254	226	61,374		61,374		61,374			7
8	TOTAL General Services	1,193,263	500,904	678,802	2,372,969		2,372,969	(46,529)	2,326,440			8
	B. Health Care and Programs											
9	Medical Director			30,000	30,000		30,000		30,000			9
10	Nursing and Medical Records	3,411,006	213,685	356,485	3,981,176		3,981,176	(24,524)	3,956,652			10
10a	Therapy											10a
11	Activities	173,535	4,617	18,520	196,672		196,672		196,672			11
12	Social Services	78,357	90	15,110	93,557		93,557		93,557			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,662,898	218,392	420,115	4,301,405		4,301,405	(24,524)	4,276,881			16
	C. General Administration											
17	Administrative	109,607		600,000	709,607		709,607		709,607			17
18	Directors Fees											18
19	Professional Services			89,392	89,392		89,392		89,392			19
20	Dues, Fees, Subscriptions & Promotions			47,253	47,253		47,253		47,253			20
21	Clerical & General Office Expenses	220,656	11,171	1,628,396	1,860,223		1,860,223	(1,575,645)	284,578			21
22	Employee Benefits & Payroll Taxes			987,116	987,116		987,116		987,116			22
23	Inservice Training & Education											23
24	Travel and Seminar			43,223	43,223		43,223	(33,873)	9,350			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			376,714	376,714		376,714		376,714			26
27	Other (specify):*											27
28	TOTAL General Administration	330,263	11,171	3,772,094	4,113,528		4,113,528	(1,609,518)	2,504,010			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,186,424	730,467	4,871,011	10,787,902		10,787,902	(1,680,571)	9,107,331			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			797,554	797,554		797,554		797,554			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			285,102	285,102		285,102	(5,493)	279,609			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			97,508	97,508		97,508		97,508			35
36	Other (specify):* mort Def Financing											36
37	TOTAL Ownership			1,180,164	1,180,164		1,180,164	(5,493)	1,174,671			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		593,137	1,257,436	1,850,573		1,850,573		1,850,573			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			179,047	179,047		179,047		179,047			42
43	Other (specify):* Marketing/AL/IL	927,381	12,652	286,557	1,226,590		1,226,590	(1,226,590)				43
44	TOTAL Special Cost Centers	927,381	605,789	1,723,040	3,256,210		3,256,210	(1,226,590)	2,029,620			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	6,113,805	1,336,256	7,774,215	15,224,276		15,224,276	(2,912,654)	12,311,622			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	(26,332)	2		4
5	Telephone, TV & Radio in Resident Rooms	(33,468)	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	(5,493)	32		10
11	Discounts, Allowances, Rebates & Refunds	(18,679)	21		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	(33,873)	24		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	(1,495,091)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(1,299,718)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (2,912,654)		\$	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))	\$ (2,912,654)		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	Miscellaneous Income	\$ (7,005)	21	1
2	Miscellaneous Income - Nursing	(24,524)	10	2
3				3
4	AL/Foundation/Marketing Salaries	(927,381)	43	4
5	AL/Foundation/Marketing Supplies	(12,652)	43	5
6	AL/Foundation/Marketing Other	(286,557)	43	6
7	Other Revenue	(20,524)	21	7
8	Laundry Income	0	4	8
9				9
10	Beauty & Barber Income	(878)	21	10
11				11
12	Dining Discounts	(20,197)	2	12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(1,299,718)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number St Pauls House & Hlth Cr Ctr# 0005165

Report Period Beginning:

7/01/2015

Ending:

6/30/2016

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	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(46,529)	0	0	0	0	0	0	0	0	0	0	(46,529)	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	(46,529)	0	0	0	0	0	0	0	0	0	0	(46,529)	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	(24,524)	0	0	0	0	0	0	0	0	0	0	(24,524)	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	(24,524)	0	0	0	0	0	0	0	0	0	0	(24,524)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(1,575,645)	0	0	0	0	0	0	0	0	0	0	(1,575,645)	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	(33,873)	0	0	0	0	0	0	0	0	0	0	(33,873)	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	(1,609,518)	0	0	0	0	0	0	0	0	0	0	(1,609,518)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(1,680,571)	0	0	0	0	0	0	0	0	0	0	(1,680,571)	29

Summary B

6/30/2016

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

[illegible]

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
<u>Lutheran Home for the Aged Inc.</u>	<u>100</u>	<u>Lutheran Home for the Aged</u>	<u>Arlington Heights</u>	<u>Lutheran Life Ministri</u>	<u>Arlington Heights</u>	<u>Parent Holding Com</u>
		<u>Pleasant View Luther Home</u>	<u>Ottawa</u>	<u>Lutheran Life Commu</u>	<u>Arlington Heights</u>	<u>Management Consul</u>
		<u>St. Pauls House & Health Care Center</u>	<u>Chicago</u>	<u>Lutheran Foundation f</u>	<u>Arlington Heights</u>	<u>Fundraising</u>
		<u>Wittenberg Lutheran Village</u>	<u>Crown Point</u>	<u>Lutheran Community</u>	<u>Arlington Heights</u>	<u>Support Services</u>
		<u>Arlington of Naples (under Construction)</u>	<u>Naples</u>			
		<u>Luthe Oaks</u>	<u>Bloomington</u>			

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	17	<u>Administrative Expenses</u>	<u>\$ 600,000</u>	<u>Lutheran Life Communities</u>	<u>0.00%</u>	<u>\$ 600,000</u>	\$	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			<u>\$ 600,000</u>			<u>\$ 600,000</u>	<u>\$ *</u>	14

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

Facility Name & ID Number St Pauls House & Hlth Cr Ctr # 0005165 Report Period Beginning: 7/01/2015 Ending: 6/30/2016

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	Roger Paulsberg	Chairman	Administrative	0.00	278,115	3	7.50	Salary	\$ 22,550	17-3	1
2	Lori Fedyk	Treasurer	Administrative	0.00	175,744	6	12.50	Salary	25,106	17-3	2
3	Marie Carlson	Vice President	Administrative	0.00	187,123	6	15.00	Salary	33,022	17-3	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 80,678		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 House & Hlth Cr Ctr # 0005165 Report Period Beginning: 7/01/2015 Ending: 7/30/2016

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 Lutheran Life Communities
Street Address 800 W. Oakton
City / State / Zip Code Arlington Heights, IL60004
Phone Number (847)368-7400
Fax Number (847) 368-7302

	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	17	Administrative	Direct Allocation			\$	\$		\$ 600,000	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					\$	\$		\$ 600,000	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	MIF Loan		X	Financing/construction		3/30/2013	\$ 6,550,000	\$ 6,000,641	3/1/2033	4.6250	\$ 283,068	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6	Int on Capital Lease		X								2,034	6	
7												7	
8												8	
9	TOTAL Facility Related						\$ 6,550,000	\$ 6,000,641			\$ 285,102	9	
	B. Non-Facility Related*												
10	Investment Income										(5,493)	10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ (5,493)	14	
15	TOTALS (line 9+line14)						\$ 6,550,000	\$ 6,000,641			\$ 279,609	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None 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.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME St Pauls House & Hlth Cr Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0005165

CONTACT PERSON REGARDING THIS REPORT N/A

TELEPHONE () FAX #: ()

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

Enter the tax index number and real estate tax assessed for 2015 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 2015.

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

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? X 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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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

A. Square Feet: 91,138

B. General Construction Type: Exterior BrickFrame BrickNumber of Stories 4

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 Pauls Resident, 2815 W. Byron, Chicago, IL 60618

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	Facility		1910	\$ 103,081	1
2					2
3	TOTALS			\$ 103,081	3

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4			1986	1986	\$ 3,871,467	\$		\$	\$	\$	4
5			1974	1974	1,311,772						5
6			1949	1949	440,643						6
7											7
8											8
	Improvement Type**										
9	Various		1972		2,363						9
10	Various		1974		4,970						10
11	Various		1975		2,390						11
12	Various		1977		3,525						12
13	Various		1979		560,281						13
14	Various		1980		74,338						14
15	Various		1981		3,653						15
16	Various		1982		157,205						16
17	Various		1983		5,074						17
18	Various		1985		219,385						18
19	Various		1986		60,006						19
20	Various		1987		4,370						20
21	Various		1988		1,500						21
22	Various		1990		5,140						22
23	Various		1991		58,255						23
24	Various		1992		2,200						24
25	Various		1993		8,500						25
26	Various		1995		17,542						26
27	Various		1996		57,995						27
28	Various		1997		6,258,224						28
29	Various		1998		164,984						29
30	Various		1999		60,741						30
31	Various		2000		56,821						31
32	Various		2001		1,607,817						32
33	Various		2002		17,908						33
34	Various		2004		39,650						34
35	Various		2008		229,668						35
36	Various		2009		78,931						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 House & Hlth Cr Ctr

0005165

Report Period Beginning:

7/01/2015

Ending:

6/30/2016

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	Various	2010	\$ 646,431	\$		\$	\$	\$	37
38	SPH Shelter Care Carpeting Ro	2011	1,690						38
39	Shelter Care Carpet Rooms 26	2011	4,258						39
40	East Building HVAC Unit Engee	2011	7,423						40
41	East AC Unit 1 of 3	2011	60,333						41
42	East AC Unit Electric	2011	14,850						42
43	1 East Chiller Breathing Mask	2011	1,375						43
44	East Chiller West Town 2 of 3	2011	54,670						44
45	East Chiller Final Electric Paym	2011	14,850						45
46	Eash Chiller West Town 3 of 3	2011	41,847						46
47	Stairwell Railing Additions	2012	16,850						47
48	Carpet for 1st and 2nd Floor in	2012	22,460						48
49	East Chiller West Town	2012	25,000						49
50	SPH Chiller System	2012	5,446						50
51	Carpet for 1st and 2nd floor in S	2012	22,460						51
52	2 East Redecoration - Architect	2013	2,500						52
53	Hot Water Tanks	2013	27,925						53
54	2 East - Architect Fees	2013	2,640						54
55	Voice/Data Cabling Project #1	2013	92,000						55
56	Wireless Project #1	2013	75,757						56
57	3rd Floor Memory Support - Re	2013	1,790						57
58	3rd Floor/ 2 East Project - Attor	2013	8,599						58
59	3rd FI MSAL Relocation 1	2013	785						59
60	3rd FI MSAL Carpeting for Relo	2013	4,696						60
61	MIF Loan Interest April	2013	15,751						61
62	2E/3FI MSAL Henkel Performa	2013	4,428						62
63	2E Henkel Electric 1	2013	30,000						63
64	2E Mid Counties Development	2013	20,174						64
65	2E/3FI MSAL Mid Counties Per	2013	3,678						65
66	2E Milwaukee Millwork 1	2013	15,593						66
67	2E/3FI MSAL Norman Mechani	2013	1,500						67
68	2E/3FI MSAL Const. Contract R	2013	1,760						68
69	2E/3FI MSAL Petrow Contractin	2013	4,950						69
70	TOTAL (lines 4 thru 69)		\$ 16,641,787	\$		\$	\$	\$	70

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

Facility Name & ID Number St Pauls House & Hlth Cr Ctr

0005165

Report Period Beginning:

7/01/2015

Ending:

6/30/2016

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	
1	Totals from Page 12A, Carried Forward		\$ 16,641,787	\$		\$	\$	\$	1
2	2E Petrow Contracting 1	2013	12,215						2
3	3FL MSAL Carpeting for Reloca	2013	1,174						3
4	MIF Loan Interest May	2013	18,527						4
5	2E HVAC Fan Coils California	2013	15,385						5
6	2E Room Signs	2013	289						6
7	3FL MSAL Internal Moves from	2013	3,509						7
8	2E Room Signs 2	2013	815						8
9	2E Wiring 1	2013	182						9
10	2E Beauty Shop Fixtures 2	2013	60						10
11	2E 3FL Architectural Drawings	2013	5,660						11
12	2E 3FL Architectural Drawings	2013	31						12
13	2E 3FL Architectural Drawings	2013	1,063						13
14	2E 3FL Wiring - Racks	2013	643						14
15	2E Call Lights	2013	11,112						15
16	2E 3FL Cabling 25%	2013	46,000						16
17	2E 3FL Coax - 50%	2013	17,425						17
18	MIF Loan Interest June	2013	19,188						18
19	2E Electrical Hardware	2013	976						19
20	2E Electrical Hardware 2	2013	44						20
21	2E Henkel Electric 2	2013	20,000						21
22	2E Mid Counties Development	2013	21,800						22
23	2E Milwaukee Millwork 2	2013	780						23
24	2E Norman Mechanical 2	2013	13,164						24
25	2E Petrow Contracting 2	2013	20,625						25
26	MIF Loan Interest July	2013	19,122						26
27	2E HVAC 2	2013	1,050						27
28	2E HVAC 3	2013	6,195						28
29	2E Architectural Drawings 4	2013	84						29
30	2E Architectural Drawings 5	2013	122						30
31	2E/ 3FL Architectural Drawings	2013	3,698						31
32	2E Norman Mechanical 3	2013	14,400						32
33	2E Artwork and Decorations 2	2013	3,360						33
34	TOTAL (lines 1 thru 33)		\$ 16,920,485	\$		\$	\$	\$	34

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

Facility Name & ID Number St Pauls House & Hlth Cr Ctr

0005165

Report Period Beginning:

7/01/2015

Ending:

6/30/2016

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	
1	Totals from Page 12B, Carried Forward		\$ 16,920,485	\$		\$	\$	\$	1
2	2E TV Mount	2013	65						2
3	2E Dome Lights	2013	1,953						3
4	1 - 2 AL Nurse Call	2014	2,860						4
5	1 - 2 AL Nurse Call	2014	11,100						5
6	1 - 2 AL Nurse Call	2014	7,200						6
7	1 - 2 AL Nurse Call	2014	19,588						7
8	2E 3FL Closing Costs on Finan	2014	5,717						8
9	2E TV Brackets	2014	105						9
10	MIF Loan Interest August	2014	20,396						10
11	2E Paint and Primer	2014	773						11
12	2E 3FL Wireless 50% Hardwar	2014	56,510						12
13	MIF Loan Interest September	2014	20,258						13
14	2E Carpeting	2014	51,701						14
15	2E Bathroom Flooring	2014	10,560						15
16	2E Beauty Shop Flooring	2014	1,490						16
17	2E Medicine Cabinets	2014	1,142						17
18	2E Medicine Cabinets 2	2014	1,650						18
19	2E Beauty Shop Electrical	2014	5,760						19
20	2E Henkel Electric 3	2014	15,000						20
21	2E Mid Counties Development	2014	19,800						21
22	2E Milwaukee Millwork 3	2014	299						22
23	2E Norman Mechanical 4	2014	8,053						23
24	2E Petrow Contracting 3	2014	9,735						24
25	2E Petrow Contracting 4	2014	23,781						25
26	3FL Carpeting	2014	23,606						26
27	2E Carpeting 2	2014	24,426						27
28	3FL Tinaglia Architects	2014	2,620						28
29	3FL Elevator 50%	2014	33,637						29
30	3FL Tinaglia Architects 2	2014	115						30
31	2E 3FL Wireless Equipment	2014	18,020						31
32	2E 3FL Wireless Labor 50%	2014	19,246						32
33	2E 3FL Coax - 50% - 2	2014	17,425						33
34	TOTAL (lines 1 thru 33)		\$ 17,355,075	\$		\$	\$	\$	34

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

Facility Name & ID Number St Pauls House & Hlth Cr Ctr

0005165

Report Period Beginning:

7/01/2015

Ending:

6/30/2016

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	
1	Totals from Page 12C, Carried Forward		\$ 17,355,075	\$		\$	\$	\$	1
2	2E Medicine Cabinets	2014	450						2
3	2E HVAC Beauty Shop, Phase	2014	2,845						3
4	2E 3FL Closing Costs, Attorney	2014	13,055						4
5	2E 3FL IT UPS and Rack	2014	6,422						5
6	MIF Loan Interest October	2014	21,284						6
7	3FL Fire Alarm System	2014	320						7
8	2E Fan Coil Repair	2014	9,495						8
9	2E Spa Tiles	2014	30						9
10	3FL Henkel Electric	2014	10,000						10
11	3FL JS Goray Tuckpointing	2014	31,845						11
12	3FL Mid Counties Supervision	2014	4,550						12
13	2E 3FL Mid Counties Supervisi	2014	15,500						13
14	3FL One Source Roofing	2014	14,455						14
15	3FL Petrow Contracting - Demo	2014	31,625						15
16	MIF Loan Interest November	2014	21,794						16
17	3FL Netrix AP Licenses	2014	2,101						17
18	3FL Insulation IMICO	2014	7,367						18
19	3FL Healthsense Stage #1	2014	9,720						19
20	3FL Waste Management - Disp	2014	1,140						20
21	3FL Waste Management - Disp	2014	1,874						21
22	3FL Avaya Phone Switches	2014	4,200						22
23	3FL Insulation	2014	12,000						23
24	3FL Asbestos Fees	2014	950						24
25	3FL Waste Removal	2014	1,598						25
26	3FL Drywall	2014	963						26
27	3FL Drywall 2	2014	172						27
28	3FL Drywall 3	2014	2,218						28
29	3FL Drywall 4	2014	2,348						29
30	2E 3FL Henkel Electric 5	2014	40,000						30
31	3FL JS Goray Facade Repairs	2014	30,425						31
32	3FL JS Goray Facade Repairs	2014	37,446						32
33	2E 3FL Cabinets	2014	9,362						33
34	TOTAL (lines 1 thru 33)		\$ 17,702,629	\$		\$	\$	\$	34

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

Facility Name & ID Number St Pauls House & Hlth Cr Ctr

0005165

Report Period Beginning:

7/01/2015

Ending:

6/30/2016

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	
1	Totals from Page 12D, Carried Forward		\$ 17,702,629	\$		\$	\$	\$	1
2	2E 3FL Mid Counties 5	2014	14,107						2
3	2E 3FL Mid Counties Roof/Tuc	2014	9,397						3
4	3FL Milwaukee Millwork 5	2014	16,285						4
5	3FL Milwaukee Millwork 6	2014	798						5
6	3FL Milwaukee Millwork 7	2014	21,978						6
7	2E 3FL Hair Salon	2014	3,013						7
8	2E 3FL Norman Mechanical 5	2014	14,577						8
9	3FL One Source Roofing 2	2014	18,731						9
10	2E 3FL Petrow Contracting 5	2014	21,435						10
11	2E 3FL Petrow Contracting 6	2014	5,925						11
12	2E 3FL Blinds/Valance	2014	8,386						12
13	2E 3FL HVAC Service Group 1	2014	4,497						13
14	2E Spa Tub	2014	20,630						14
15	2E 3FL Italica Patch Cords	2014	895						15
16	2E 3FL Italica 25% Contract	2014	41,400						16
17	3FL Sheet Vinyl 1	2014	10,884						17
18	3FL Sheet Vinyl 2	2014	10,884						18
19	2E 3FL Paint	2014	516						19
20	2E 3FL Paint	2014	1,205						20
21	3FL Wall Mount LED Lights	2014	672						21
22	3FL Architect Consult	2014	373						22
23	2E 3FL Waste Disposal	2014	556						23
24	3FL Wanderguard	2014	7,035						24
25	3FL Wanderguard 2	2014	14,069						25
26	MIF Loan Interest December	2014	22,172						26
27	3FL Flooring Sheet Vinyl	2014	1,490						27
28	3FL Access Points - Nurse Cal	2014	8,055						28
29	3FL Drapes	2014	2,645						29
30	3FL TSG	2014	975						30
31	3FL Decorations	2014	872						31
32	3FL Healthsense - Nurse Call	2014	22,955						32
33	2 West Chiller	2014	125,847						33
34	TOTAL (lines 1 thru 33)		\$ 18,135,888	\$		\$	\$	\$	34

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

Facility Name & ID Number St Pauls House & Hlth Cr Ctr

0005165

Report Period Beginning:

7/01/2015

Ending:

6/30/2016

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12E, Carried Forward		\$ 18,135,888	\$		\$	\$	\$	1
2 3FL Italica	2014	4,600						2
3 3FL Carpeting - Rooms & Corri	2014	23,606						3
4 3FL Kitchen Elevator - 2	2014	33,637						4
5 3FL Drywall - Ceiling Tiles	2014	14,218						5
6 2E 3FL Henkel Electric	2014	20,000						6
7 3FL Interstate Asbestos Remov	2014	20,570						7
8 3FL Cabinets	2014	5,659						8
9 2E Mid Counties Professional S	2014	11,668						9
10 3FL Custom Doors	2014	2,316						10
11 3FL Door Keypads	2014	562						11
12 2E 3FL Norman Mechanical	2014	10,000						12
13 2E 3FL Petrow Contracting	2014	37,280						13
14 3FL Pipe Insulation	2014	4,800						14
15 3FL Imico - Pipe Insulation	2014	11,383						15
16 3FL Mid Counties - Moisture Pa	2014	1,618						16
17 3FL Painting	2014	338						17
18 MIF Loan Interest January	2014	24,638						18
19 2E 3FL HVAC	2014	1,115						19
20 2E 3FL Electrical IT Closet	2014	3,500						20
21 2E 3FL Roller Shades	2014	645						21
22 2E 3FL Additional Wireless APs	2014	3,500						22
23 3FL Fire Alarm Set Up	2014	771						23
24 2E 3FL Sprinklers	2014	791						24
25 2E 3FL Sprinklers	2014	4,192						25
26 3FL Painting	2014	227						26
27 3FL Painting	2014	191						27
28 2E 3FI Painting	2014	534						28
29 2E 3FL Painting	2014	405						29
30 3FL Wanderguard	2014	240						30
31 2E 3FL Waste Removal	2014	1,005						31
32 ECX satin Aluminim Flag Pole	2008	2,187						32
33 Entrance Sign in front of buildin	2008	3,370						33
34 TOTAL (lines 1 thru 33)		\$ 18,385,453	\$		\$	\$	\$	34

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

Facility Name & ID Number St Pauls House & Hlth Cr Ctr

0005165

Report Period Beginning:

7/01/2015

Ending:

6/30/2016

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	
1	Totals from Page 12F, Carried Forward		\$ 18,385,453	\$		\$	\$	\$	1
2	3 FL Architect Visit IDPH	2014	689						2
3	2E HVAC	2014	1,226						3
4	2E 3FL Supplies	2014	427						4
5	MIF Loan Interest February	2014	25,428						5
6	3FL Sprinklers	2014	1,170						6
7	3FL Wall Plates	2014	150						7
8	3FL Drywall	2014	2,104						8
9	3FL Henkel Electric Final	2014	35,750						9
10	3FL Mid Counties Final	2014	100						10
11	3FL Norman Mechanical Final	2014	48,020						11
12	2E 3FL Petrow Final	2014	64,570						12
13	2E Fire Alarms - Spa	2014	690						13
14	3FL Paint and Supplies	2014	1,256						14
15	3FL Window Fasteners	2014	7						15
16	3FL Wanderguard	2014	2,590						16
17	3FL Elevator	2014	3,764						17
18	MIF Loan Interest March	2014	23,112						18
19	3FL Waste Management	2014	55						19
20	3FL Valances and Blinds	2014	2,256						20
21	3FL HVAC	2014	856						21
22	3FL Norman Mechanical	2014	1,449						22
23	2E Fire Alarms	2014	2,669						23
24	2E Spa Sprinklers	2014	4,026						24
25	3FL IT Cabinet	2014	10,000						25
26	3FL Signage	2014	310						26
27	3FL Signage	2014	141						27
28	3FL Signage	2014	158						28
29	3FL Healthsense	2014	3,000						29
30	3FL Elevator	2014	699						30
31	2E 3FL Final Architectural Visit	2014	1,170						31
32	2E 3FL Door Locks	2014	569						32
33	2E 3FL Door Closers	2014	285						33
34	TOTAL (lines 1 thru 33)		\$ 18,624,151	\$		\$	\$	\$	34

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

Facility Name & ID Number St Pauls House & Hlth Cr Ctr

0005165

Report Period Beginning:

7/01/2015

Ending:

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12G, Carried Forward		\$ 18,624,151	\$		\$	\$	\$	1
2 2E Smoke Detectors	2014	1,895						2
3 2E Carpet Finishing	2014	589						3
4 1 - 2 AL Nurse Call	2014	1,750						4
5 1 - 2 AL Nurse Call	2014	3,413						5
6 Railings in Loading Dock	2015	1,895						6
7 Safety Glass for Door	2015	921						7
8 2E Bathroom Flooring	2015	10,560						8
9 Fire Door and Frame - 2 East	2015	9,250						9
10 Security Camera System	2015	10,100						10
11 Kitchen Waste Piping	2015	21,350						11
12 Fire Panel	2016	56,000						12
13 Sink Installation in 2nd Floor Di	2016	3,650						13
14								14
15								15
16 Financial Statement Depreciation			662,337		662,337		13,104,985	16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 18,745,524	\$ 662,337		\$ 662,337	\$	\$ 13,104,985	34

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

Facility Name & ID Number

St Pauls House & Hlth Cr Ctr

STATE OF ILLINOIS

0005165

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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	\$ 2,385,919	\$ 131,165	\$ 131,165	\$	Var	\$ 1,769,808	71
72	Current Year Purchases	250,093	4,051	4,051		Var	4,051	72
73	Fully Depreciated Assets	1,518,122				Var	1,518,122	73
74								74
75	TOTALS	\$ 4,154,134	\$ 135,216	\$ 135,216	\$		\$ 3,291,981	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	Facility	Van	1994	\$ 37,650	\$	\$	\$		\$ 37,650
77	Facility	Bus	2007	15,000					15,000
78	Facility	Bus paint/repair	2007	7,796					7,796
79									
80	TOTALS			\$ 60,446	\$	\$	\$		\$ 60,446

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)			\$ 23,063,185	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$ 797,554	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$ 797,554	
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)			\$ 16,457,412	

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		\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92	CIP Building	\$ 3,147
93	CIP Equipment	53,317
94		
95		\$ 56,464

* 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

NO
16. Rental Amount for movable equipment:

\$97,508

Description:

Nursing Medical Equipment

(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

C. CONTRACTUAL INCOME

ALLOCATION OF COSTS (d)

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

		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)	\$			

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	39-3	hrs	\$	8,091	\$ 411,839	\$	8,091	\$ 411,839	1
2	Licensed Speech and Language Development Therapist	39-3	hrs		4,368	217,630		4,368	217,630	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs		9,004	492,319		9,004	492,319	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				593,137		593,137	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Other (specify): Lab & X-ray	39-3					102,537		102,537	12
13	Other (specify):									13
14	TOTAL			\$	21,463	\$ 1,121,788	\$ 695,674	21,463	\$ 1,817,462	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	\$ 919,852	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 1,403,923)	2,838,137		3
4	Supply Inventory (priced at cost)	51,823		4
5	Short-Term Investments	637,848		5
6	Prepaid Insurance	16,012		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,463,672	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	3,208,150		11
12	Long-Term Investments			12
13	Land	103,081		13
14	Buildings, at Historical Cost	18,739,966		14
15	Leasehold Improvements, at Historical Cost	5,557		15
16	Equipment, at Historical Cost	4,214,581		16
17	Accumulated Depreciation (book methods)	(16,457,413)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	56,464		19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attachment	21,920		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 9,892,306	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 14,355,978	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,053,111	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	330,889		28
29	Short-Term Notes Payable	229,887		29
30	Accrued Salaries Payable	525,929		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	(1,617,866)		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 521,950	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	5,770,754		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Constellation Lighting Payable	153,834		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 5,924,588	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 6,446,538	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 7,909,440	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 14,355,978	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 6,992,997	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 6,992,997	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	916,443	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)	\$ 916,443	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)	\$ 7,909,440	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number St Pauls House & Hlth Cr Ctr

0005165

Report Period Beginning: 7/01/2015

Ending: 6/30/2016

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	\$ 12,638,965	1
2	Discounts and Allowances for all Levels	(6,084,712)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,554,253	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	5,300,680	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 5,300,680	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	878	13
14	Non-Patient Meals	26,332	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	555,961	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	59,990	19
20	Radiology and X-Ray	36,680	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 679,841	23
	D. Non-Operating Revenue		
24	Contributions	53,511	24
25	Interest and Other Investment Income***	3,102,575	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3,156,086	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	<u>See Attachment</u>		28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 449,859	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 16,140,719	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,372,969	31
32	Health Care	4,088,820	32
33	General Administration	4,113,528	33
	B. Capital Expense		
34	Ownership	1,180,164	34
	C. Ancillary Expense		
35	Special Cost Centers	3,289,748	35
36	Provider Participation Fee	179,047	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 15,224,276	40
41	Income before Income Taxes (line 30 minus line 40)**	916,443	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 916,443	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 1,013,789	44
45	Private Pay - Net Inpatient Revenue	4,975,760	45
46	Medicare - Net Inpatient Revenue	564,704	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 6,554,253	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	2,558	2,869	\$ 149,571	\$ 52.13	1
2	Assistant Director of Nursing					2
3	Registered Nurses	40,567	42,767	1,478,966	34.58	3
4	Licensed Practical Nurses	19,748	21,317	578,900	27.16	4
5	CNAs & Orderlies	91,631	100,229	1,431,441	14.28	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,725	1,985	39,489	19.89	8
9	Activity Director	1,800	1,950	53,674	27.53	9
10	Activity Assistants	6,037	6,578	124,998	19.00	10
11	Social Service Workers	4,907	5,473	149,164	27.25	11
12	Dietician	1,767	1,968	50,866	25.85	12
13	Food Service Supervisor	5,770	6,130	178,856	29.18	13
14	Head Cook	5,675	6,503	88,736	13.65	14
15	Cook Helpers/Assistants	30,592	32,523	354,160	10.89	15
16	Dishwashers					16
17	Maintenance Workers	15,149	16,210	339,450	20.94	17
18	Housekeepers	16,543	18,259	209,702	11.48	18
19	Laundry	5,737	6,391	71,173	11.14	19
20	Administrator	1,744	1,950	109,607	56.21	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	15,278	16,376	450,203	27.49	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	1,917	2,142	32,355	15.11	31
32	Other Health C: AL/IL/Marketing	8,003	8,696	222,494	25.59	32
33	Other(specify) MDS Coordinator					33
34	TOTAL (lines 1 - 33)	277,146	300,316	\$ 6,113,805 *	\$ 20.36	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	monthly	30,000	9-03	36
37	Medical Records Consultant	38	2,577	10-3	37
38	Nurse Consultant	monthly	1,285	10-3	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	monthly	852	11-03	44
45	Social Service Consultant	224	14,810	12-03	45
46	Other(specify) Chaplin	monthly	10,900	11-03	46
47	Senior Fit	984	32,148	10-3	47
48					48
49	TOTAL (lines 35 - 48)	1,246	\$ 92,572		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	2,269	\$ 154,556	10-3	50
51	Licensed Practical Nurses	557	25,073	10-3	51
52	Certified Nurse Assistants/Aides	1,685	35,500	10-3	52
53	TOTAL (lines 50 - 52)	4,511	\$ 215,129		53

XX. GENERAL INFORMATION:

STATE OF ILLINOIS

0005165

Report Period Beginning:

7/01/2015

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- (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. LEADING AGE \$11,668.96
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases?
What was the average life used for new equipment added during this period? Yes
10 Year
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 63,054 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 179,047
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? Yes Indicate the amount. \$ 26,332
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 100%
- d. Have vehicle usage logs been maintained? Yes
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
- g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: CliftonLarsonAllen LLP
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees