

		FOR BHF USE					

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2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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>0056085</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																															
Facility Name: <u>St Pauls Senior Community</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2020</u> to <u>12/31/2020</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> <u>Director</u></td></tr><tr><td>(Firm Name & Address) <u>CliftonLarsonAllen LLP</u> <u>600 Washington Ave, Suite 1800, St. Louis, MO 63101</u></td></tr><tr><td>(Telephone) <u>(314) 925-4300</u> Fax # <u>(314) 925-4350</u></td></tr><tr><td>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></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____	(Title) _____	(Signed) _____	Paid Preparer	(Print Name and Title) <u>Kevin Wellen, CPA</u> <u>Director</u>	(Firm Name & Address) <u>CliftonLarsonAllen LLP</u> <u>600 Washington Ave, Suite 1800, St. Louis, MO 63101</u>	(Telephone) <u>(314) 925-4300</u> Fax # <u>(314) 925-4350</u>	MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630																																				
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Date of Initial License for Current Owners: <u>12/1/2019</u>																																																	
Type of Ownership:																																																	
<table><tr><td>☐</td><td>VOLUNTARY, NON-PROFIT</td><td>☒</td><td>PROPRIETARY</td><td>☐</td><td>GOVERNMENTAL</td></tr><tr><td>☐</td><td>Charitable Corp.</td><td>☐</td><td>Individual</td><td>☐</td><td>State</td></tr><tr><td>☐</td><td>Trust</td><td>☐</td><td>Partnership</td><td>☐</td><td>County</td></tr><tr><td>IRS Exemption Code _____</td><td></td><td>☐</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td></td><td></td><td>☐</td><td>"Sub-S" Corp.</td><td></td><td></td></tr><tr><td></td><td></td><td>☒</td><td>Limited Liability Co.</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Trust</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Other _____</td><td></td><td></td></tr></table>		☐	VOLUNTARY, NON-PROFIT	☒	PROPRIETARY	☐	GOVERNMENTAL	☐	Charitable Corp.	☐	Individual	☐	State	☐	Trust	☐	Partnership	☐	County	IRS Exemption Code _____		☐	Corporation	☐	Other _____			☐	"Sub-S" Corp.					☒	Limited Liability Co.					☐	Trust					☐	Other _____		
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In the event there are further questions about this report, please contact:																																																	
Name: <u>Kevin Wllen, CPA</u> Telephone Number: <u>(314) 925-4300</u>																																																	
Email Address: _____																																																	

Facility Name & ID Number St Pauls Senior Community

0056085 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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>108</u>	Skilled (SNF)	<u>108</u>	<u>39,528</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			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 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>9,257</u>	<u>13,568</u>	<u>6,695</u>	<u>29,520</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC		<u>6,225</u>		<u>6,225</u>	12
13	DD 16 OR LESS					13
14	TOTALS	<u>9,257</u>	<u>19,793</u>	<u>6,695</u>	<u>35,745</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 72.88%

D. How many bed reserve days during this year were paid by the Department?
None (Do not include bed reserve days in Section B.)

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

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

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

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

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

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 12/1/2019 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 108 and days of care provided 5,172

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: 12/31/2020 Fiscal Year: 12/31/2020

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

Facility Name & ID Number St Pauls Senior Community # 0056085 Report Period Beginning: 1/1/2020 Ending: 12/31/2020
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	421,871	93,245	14,139	529,255		529,255		529,255			1
2	Food Purchase		360,599		360,599		360,599	(238)	360,361			2
3	Housekeeping	194,261	38,507	14,703	247,471		247,471		247,471			3
4	Laundry	48,069	21,911		69,980		69,980		69,980			4
5	Heat and Other Utilities			271,443	271,443		271,443		271,443			5
6	Maintenance	97,257	15,058	182,796	295,111		295,111		295,111			6
7	Other (specify):*											7
8	TOTAL General Services	761,458	529,320	483,081	1,773,859		1,773,859	(238)	1,773,621			8
	B. Health Care and Programs											
9	Medical Director			14,500	14,500		14,500		14,500			9
10	Nursing and Medical Records	3,041,379	135,903	604,413	3,781,695		3,781,695	(15,000)	3,766,695			10
10a	Therapy											10a
11	Activities	120,379	12,557	5,436	138,372		138,372		138,372			11
12	Social Services	63,926		2,538	66,464		66,464		66,464			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,225,684	148,460	626,887	4,001,031		4,001,031	(15,000)	3,986,031			16
	C. General Administration											
17	Administrative	137,126		598,182	735,308		735,308	(30,586)	704,722			17
18	Directors Fees											18
19	Professional Services			148,193	148,193		148,193	(92,616)	55,577			19
20	Dues, Fees, Subscriptions & Promotions			7,562	7,562		7,562		7,562			20
21	Clerical & General Office Expenses	211,689	34,876	290,410	536,975		536,975	(113,792)	423,183			21
22	Employee Benefits & Payroll Taxes			901,236	901,236		901,236		901,236			22
23	Inservice Training & Education											23
24	Travel and Seminar			422	422		422		422			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			173,680	173,680		173,680		173,680			26
27	Other (specify):*											27
28	TOTAL General Administration	348,815	34,876	2,119,685	2,503,376		2,503,376	(236,994)	2,266,382			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,335,957	712,656	3,229,653	8,278,266		8,278,266	(252,232)	8,026,034			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			3,518	3,518		3,518	704,302	707,820			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			422	422		422	(422)				32
33	Real Estate Taxes			451,631	451,631		451,631		451,631			33
34	Rent-Facility & Grounds			530,000	530,000		530,000	(530,000)				34
35	Rent-Equipment & Vehicles			26,247	26,247		26,247		26,247			35
36	Other (specify):* Personal Property Taxes			4,200	4,200		4,200		4,200			36
37	TOTAL Ownership			1,016,018	1,016,018		1,016,018	173,880	1,189,898			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		463,592	746,943	1,210,535		1,210,535		1,210,535			39
40	Barber and Beauty Shops		81		81		81		81			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			210,246	210,246		210,246		210,246			42
43	Other (specify):* AL/IL/Marketing	572,457		82,249	654,706		654,706	(654,706)				43
44	TOTAL Special Cost Centers	572,457	463,673	1,039,438	2,075,568		2,075,568	(654,706)	1,420,862			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,908,414	1,176,329	5,285,109	11,369,852		11,369,852	(733,058)	10,636,794			45

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

	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	(238)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(149)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(10,848)	21		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(78,718)	21		24
25	Fund Raising, Advertising and Promotional	(21,414)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(639,005)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (750,372)		\$	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)	17,314		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 17,314		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (733,058)		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		\$		1
2	AL/IL/Marketing Salaries	(572,457)	43	2
3	AL/IL/Marketing Other	(60,835)	43	3
4	Technology/Tele/Cable Fee	(4,439)	21	4
5	Guest Apt Rental Revenue	(100)	21	5
6	Vending Machine Revenue	(390)	21	6
7	Miscellaneous Income	(784)	21	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(639,005)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number St Pauls Senior Community# 0056085

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(238)	0	0	0	0	0	0	0	0	0	0	(238)	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	(238)	0	0	0	0	0	0	0	0	0	0	(238)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	(15,000)	0	0	0	0	0	0	0	0	(15,000)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	(15,000)	0	0	0	0	0	0	0	0	(15,000)	16
	C. General Administration													
17	Administrative	0	0	(30,586)	0	0	0	0	0	0	0	0	(30,586)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	(92,616)	0	0	0	0	0	0	0	0	(92,616)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(95,279)	487	(19,000)	0	0	0	0	0	0	0	0	(113,792)	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	(95,279)	487	(142,202)	0	0	0	0	0	0	0	0	(236,994)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(95,517)	487	(157,202)	0	0	0	0	0	0	0	0	(252,232)	29

STATE OF ILLINOIS

Facility Name & ID Number

St Pauls Senior Community

#

0056085

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

Summary B

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	698,873	5,429	0	0	0	0	0	0	0	0	704,302	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(149)	326,649	(326,922)	0	0	0	0	0	0	0	0	(422)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(530,000)	0	0	0	0	0	0	0	0	0	(530,000)	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	(149)	495,522	(321,493)	0	0	0	0	0	0	0	0	173,880	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):*	(654,706)	0	0	0	0	0	0	0	0	0	0	(654,706)	43
44	TOTAL Special Cost Centers	(654,706)	0	0	0	0	0	0	0	0	0	0	(654,706)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(750,372)	496,009	(478,695)	0	0	0	0	0	0	0	0	(733,058)	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 PG6-Supp		See PG6-Supp		See PG6-Supp		

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

☒ YES☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34	Rent	\$ 530,000	TI - Belleville LLC		\$	(530,000)	1
2	V	30	Depreciation		TI - Belleville LLC		698,873	698,873	2
3	V	32	Interest		TI - Belleville LLC		326,649	326,649	3
4	V	21	Administrative Fees		TI - Belleville LLC		487	487	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			\$ 530,000			\$ 1,026,009	\$ * 496,009	14

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

Facility Name & ID Number St Pauls Senior Community # 0056085 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

VII. RELATED PARTIES (continued)

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)
15	V	22 Insurance	\$ 57	CarePlus Health Plus		\$ 57	\$ 15
16	V	22 Insurance	281,160	Cost Plus Insurance		281,160	16
17	V	26 Insurance	155,742	LTC Plus Insurance, Inc.		155,742	17
18	V	17 Management-Operating	598,182	Tutera Health Care Service		567,596	(30,586) 18
19	V	19 Management-Data Processing	92,616	Tutera Health Care Service			(92,616) 19
20	V	30 Management-Depreciation		Tutera Health Care Service		5,429	5,429 20
21	V	10 Management-Clinical Director Fee	15,000	Tutera Health Care Service			(15,000) 21
22	V	21 Management-Accounting Mgr Fee	19,000	Tutera Health Care Service			(19,000) 22
23	V	32 Interest	422	Tutera Investments			(422) 23
24	V	11 Activities - Supplies	107	Walnut Creek Management Company, LLC		107	24
25	V	10 Nursing Admin - Sm equip	1,297	Walnut Creek Management Company, LLC		1,297	25
26	V	24 Travel & Seminar	394	Walnut Creek Management Company, LLC		394	26
27	V	6 Maintenance & Repairs	5,596	Walnut Creek Management Company, LLC		5,596	27
28	V	1 Dietary - Sm equip	697	Walnut Creek Management Company, LLC		697	28
29	V	3 Housekeeping - Supplies & Equip	2,595	Walnut Creek Management Company, LLC		2,595	29
30	V	19 Purchased Svs/Data Processing	11,474	Walnut Creek Management Company, LLC		11,474	30
31	V	20 Help Wanted Ads & Licenses	(243)	Walnut Creek Management Company, LLC		(243)	31
32	V	21 Supplies, Sm Equip, Postage	13,573	Walnut Creek Management Company, LLC		13,573	32
33	V	4 Laundry - Sm equip	603	Walnut Creek Management Company, LLC		603	33
34	V	21 Employment Expense	9,258	Critical Care Rx, LLC		9,258	34
35	V	10 Pharmacy Consultant	5,610	Critical Care Rx, LLC		5,610	35
36	V	39 Drugs	70,866	Critical Care Rx, LLC		70,866	36
37	V	21 Admin/Gen Misc	162	Critical Care Rx, LLC		162	37
38	V	32 Interest	326,500	Tutera Investments (TI Belleville)			(326,500) 38
39	Total		\$ 1,610,668			\$ 1,131,973	\$ * (478,695) 39

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

Facility Name & ID Number

St Pauls Senior Community

0056085

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

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	Tutera Investments, Inc	100%	Windsor Rehab & Health Care Center	Terrell, TX	The Atriums Senior Li	Overland Park, KS	IL/AL	1
2			Bethany Rehab & Health Care Center	DeKalb, IL	Carnegie Village Senior	Belton, MO	IL/AL	2
3			Auburn Rehabilitation & Health Care Center	Auburn, IL	Continua Home Health	Kansas City, MO	Home Health	3
4			Coulterville Rehab & Health Care Center	Coulterville, IL	Country Gardens Asst	Muskogee, OK	AL	4
5			Crystal Pines Rehab & Health Care Center	Crystal Lake, IL	Lamar Court Assisted	Overland Park, KS	AL	5
6			Dixon Rehab & Health Care Center	Dixon, IL	Oakley Court Assisted	Freeport, IL	AL	6
7			Fair Oaks Rehab & Health Care Center	South Beloit, IL	Rose Estates Assisted I	Overland Park, KS	AL	7
8			Hamilton Memorial Rehab & Health Care Center	McLeansboro, IL	Stratford Commons M	Overland Park, KS	Memory Care	8
9			Highland Rehab & Health Care Center	Kansas City, MO	Victory Hills Senior Li	Kansas City, MO	IL/AL	9
10			Hillsboro Rehab & Health Care Center	Hillsboro, IL	Wesley Court Assisted	Boling Springs, SC	AL	10
11			Lakeland Rehab & Health Care Center	Effingham, IL	Willow Place Asst. Liv.	Laurinburg, NC	AL	11
12			Matton Rehab & Health Care Center	Mattoon Il	Missiona Chateua Seni	Prairie Village, KS	AL/IL	12
13			Meridian Rehab & Health Care Center	Wichita, KS	Tiffany Springs SLC	Kansas City, MO	AL/IL	13
14			Metropolis Rehab & Health Care Center	Metropolis, IL				14
15			Monterey Park Rehab & Health Care Center	Independence, MO	Columbia 7611 LC	Kansas City, MO	Building Company	15
16			Montgomery Children's Specialty Center	Montgomery, AL	Tutera Health Care Se	Kansas City, MO	Mgmt Company	16
17			Charlton Place Rehab & Health Care Center	Deatsville, AL	CarePlus Health Plans	Kansas City, MO	Insurance Company	17
18			Westridge Gardens Rehab & Health Care Center	Raytown, MO	Walnut Creek Mgmt C	Kansas City, MO	Mgmt Company	18
19			Willow Care Rehab & Health Care Center	Hannibal, MO	Walnut Creek New Eng	Kansas City, MO	Mgmt Company	19
20			Aburn Rehab & Health Care Center	Auburn, IL	LTC Plus Insurance In	Kansas City, MO	Insurance Company	20
21			Carlenville Rehab & Health Care Center	Carlenville, IL	Tutera Investments, LI	Kansas City, MO	Mgmt Company	21
22			Stratford Rehab & Health Care Center	Overland Park, KS	Tutera Group, Inc.	Kansas City, MO	Mgmt Company	22
23			Carnegie Village Rehab & Health Care Center	Belton, MO	JCT Capital, Inc.	Kansas City, MO	Mgmt Company	23
24			Tiffany Springs Rehab & Health Care Center	Kansas City, MO	IPM, Inc.	Kansas City, MO	Property Mgt	24
25			Northland Rehab & Health Care Center	Kansas City, MO				25
26								26
27								27
28								28
29								29
30								30

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	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 Senior Community# 0056085

Report Period Beginning:

1/1/2020Ending: 2/31/2020

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

Tutera Health Care Services

Street Address

7611 State Line Road

City / State / Zip Code

Kansas City, Missouri 64114

Phone Number

(816) 444-0900

Fax Number

(816) 822-0081

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	Management Fee- Operating	Direct Costs	287,210,821	71	\$ 15,078,459	\$ 10,830,799	10,811,520	\$ 567,601	1
2	30	Management Fee- Depreciation	Direct Costs	287,210,821	71	144,230		10,811,520	5,429	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					\$ 15,222,689	\$ 10,830,799		\$ 573,030	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	Note Payable (TI_Belleville)	X				12/2019	\$	8,240,027			\$	303,092	1
2	Note Payable (TI_Belleville)	X		Working Capital LOC		12/2019		2,604,398				23,557	2
3	Interest Income Offset											(149)	3
4	Related Party Offset											(326,500)	4
5													5
	Working Capital												
6	Tutera Investments	X		Working Capital LOC			400,000	50,422		0.0100		422	6
7	Related Party Offset											(422)	7
8													8
9	TOTAL Facility Related						\$	400,000	\$	10,894,847			9
	B. Non-Facility Related*												
10													10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$		\$			\$	14
15	TOTALS (line 9+line14)						\$	400,000	\$	10,894,847			15

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

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

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

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME St Pauls Senior Community COUNTY St Clair

FACILITY IDPH LICENSE NUMBER 0056085

CONTACT PERSON REGARDING THIS REPORT Kiley Brooks

TELEPHONE (816) 444-0900 FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2019 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 2019.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>08-21.0-119-026</u>	<u>Long-Term Care</u>	\$ <u>451,631.46</u>	\$ <u>451,631.46</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>451,631.46</u></u>	\$ <u><u>451,631.46</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? YES X NO

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

C. Tax Bills

Attach copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 89,383 B. General Construction Type: Exterior Brick, Vinyl Frame Number of Stories

C. Does the Operating Entity? (a) Own the Facility (X) (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (X) (a) Own the Equipment (b) Rent equipment from a Related Organization. (X) (c) Rent equipment from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)
List entity name, type of business, square footage, and number of beds/units available (where applicable).

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

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Long-Term Care	178,000	2019	\$ 929,297	1
2					2
3	TOTALS	178,000		\$ 929,297	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	134		2019	2015	\$ 8,436,292	\$ 281,210	30	\$ 281,210	\$	\$ 304,644	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Land Improvements (TI-Belleville)			2015	190,123	12,673	15	12,673		13,731	9
10											10
11											11
12	CU4 Compressor Replacement			2020	13,666	683	10	683		683	12
13	CU2 & CU5 Compressor Replacement			2020	6,585	274	10	274		274	13
14	Dining Room Floor Replacement - Carpet			2020	7,696	128	10	128		128	14
15	1st Floor South Floor Replacement - Lotus Room (Rehab Area) Carpet			2020	30,058	250	10	250		250	15
16	2nd Level North Floor Replacement - Carpet			2020	38,029	317	10	317		317	16
17											17
18	Home Office Depreciation					5,429		5,429			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

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	N/A							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)	\$ 8,722,449	\$ 300,964		\$ 300,964		\$ 320,027	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	\$2,834,914	\$404,991	\$404,991	\$	Various	\$438,737	71
72	Current Year Purchases	24,960	1,865	1,865		7	1,865	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$2,859,874	\$406,856	\$406,856	\$		\$440,602	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				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

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)	\$12,511,620
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$707,820
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$707,820
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)	\$760,629

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	Apts Fixed Assets are in a separate corporate entity with the CHOW	\$	\$	\$	86
87					87
88	Land	214,453			88
89	Building & Land Improvements	1,990,710	67,820	73,471	89
90	Equipment	654,212	93,458	101,247	90
91	TOTALS	\$2,859,375	\$161,278	\$174,718	91

G. Construction-in-Progress

	Description	Cost	
92	Work in Process	\$8,540	92
93			93
94			94
95		\$8,540	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?

YES

X

NO

If NO, see instructions.

		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

X

NO

Terms: *

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

15. Is Movable equipment rental included in building rental?

YES

X

NO
16. Rental Amount for movable equipment: \$26,247Description: Nursing Equipment, Plant, Copier (see WTB)

(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.

HFS 3745 (N-4-99)

IL478-2471

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

12345678										
	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	V39-03	hrs	\$	6,461	\$ 338,480	\$	6,461	\$ 338,480	1
2	Licensed Speech and Language Development Therapist	V39-03	hrs		1,506	93,148		1,506	93,148	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	V39-03	hrs		4,621	267,226	3,153	4,621	270,379	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	V39-02	# of prescripts				182,867		182,867	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
10			hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See WTB	V39-02,03				48,089	277,572		325,661	13
14	TOTAL			\$	12,588	\$ 746,943	\$ 463,592	12,588	\$ 1,210,535	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	\$ 393,993	\$ 198,732	1
2	Cash-Patient Deposits	7,518	7,518	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	188,519	188,519	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	157,938	157,938	6
7	Other Prepaid Expenses	321,002	321,002	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,068,970	\$ 873,709	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		929,297	13
14	Buildings, at Historical Cost		190,123	14
15	Leasehold Improvements, at Historical Cost	96,035	8,532,327	15
16	Equipment, at Historical Cost	24,960	2,859,873	16
17	Accumulated Depreciation (book methods)	(3,518)	(760,629)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Other Assets</u>	475,523	509,539	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 593,000	\$ 12,260,530	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,661,970	\$ 13,134,239	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 851,086	\$ 851,086	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	7,518	7,518	28
29	Short-Term Notes Payable	50,422	50,422	29
30	Accrued Salaries Payable	255,422	255,422	30
31	Accrued Taxes Payable (excluding real estate taxes)	247,119	247,119	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable		25,422	33
34	Deferred Compensation	748,822	748,822	34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Other Accrued Expenses</u>	231,967	231,967	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,392,356	\$ 2,417,778	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		10,844,425	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 10,844,425	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,392,356	\$ 13,262,203	46
47	TOTAL EQUITY (page 18, line 24)	\$ (730,386)	\$ (127,964)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,661,970	\$ 13,134,239	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 122,916	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 122,916	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(853,302)	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)	\$ (853,302)	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)	\$ (730,386)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number St Pauls Senior Community

0056085

Report Period Beginning: 1/1/2020

Ending:

12/31/2020

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	\$ 9,058,648	1
2	Discounts and Allowances for all Levels	(3,735,045)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,323,603	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,350,628	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 4,350,628	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	238	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	275,674	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	35,169	19
20	Radiology and X-Ray	43,352	20
21	Other Medical Services	15,041	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 369,474	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	149	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 149	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous Income</u>	5,713	28
28a	<u>COVID-19 PHE Funding</u>	466,983	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 472,696	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,516,550	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,773,859	31
32	Health Care	4,001,031	32
33	General Administration	2,503,376	33
	B. Capital Expense		
34	Ownership	1,016,018	34
	C. Ancillary Expense		
35	Special Cost Centers	1,865,322	35
36	Provider Participation Fee	210,246	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 11,369,852	40
41	Income before Income Taxes (line 30 minus line 40)**	(853,302)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (853,302)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 1,790,804	44
45	Private Pay - Net Inpatient Revenue	4,690,958	45
46	Medicare - Net Inpatient Revenue	(1,182,274)	46
47	Other-(specify) <u>Managed Care</u>	(210,926)	47
48	Other-(specify) <u>Hospice</u>	235,041	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,323,603	49

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

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

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

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

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,456	1,528	\$ 69,584	\$ 45.54	1
2	Assistant Director of Nursing					2
3	Registered Nurses	18,941	20,596	948,228	46.04	3
4	Licensed Practical Nurses	22,750	25,017	854,225	34.15	4
5	CNAs & Orderlies	54,105	60,335	1,135,170	18.81	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,602	1,727	30,548	17.69	9
10	Activity Assistants	5,927	6,338	89,831	14.17	10
11	Social Service Workers	2,136	2,318	63,926	27.58	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	23,740	25,617	421,871	16.47	15
16	Dishwashers					16
17	Maintenance Workers	3,360	3,692	97,257	26.34	17
18	Housekeepers	12,498	13,751	194,261	14.13	18
19	Laundry	3,187	3,412	48,069	14.09	19
20	Administrator	1,688	1,760	137,126	77.91	20
21	Assistant Administrator					21
22	Other Administrative	693	721	17,107	23.73	22
23	Office Manager					23
24	Clerical	12,137	13,262	211,689	15.96	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	931	1,039	17,065	16.42	31
32	Other Health Care(specify)					32
33	Other(specify) <u>AL/IL/Marketing</u>	23,034	24,245	572,457	23.61	33
34	TOTAL (lines 1 - 33)	188,185	205,358	\$ 4,908,414 *	\$ 23.90	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 11,131	V01-3	35
36	Medical Director	Monthly	14,500	V09-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	8,220	V10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	2,538	V11-3	44
45	Social Service Consultant	Monthly	2,538	V12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 38,927		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	631	\$ 40,098	V10-3	50
51	Licensed Practical Nurses	932	45,386	V10-3	51
52	Certified Nurse Assistants/Aides	12,818	427,197	V10-3	52
53	TOTAL (lines 50 - 52)	14,381	\$ 512,681		53

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? <u>No</u> (2) Are there any dues to nursing home associations included on the cost report? <u>No</u> If YES, give association name and amount. <u>N/A</u> (3) Did the nursing home make political contributions or payments to a political action organization? <u>No</u> If YES, have these costs been properly adjusted out of the cost report? <u>N/A</u> (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? <u>No</u> If YES, what is the capacity? <u>N/A</u> (5) Have you properly capitalized all major repairs and equipment purchases? <u>Yes</u> What was the average life used for new equipment added during this period? _____ (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ <u>31,773</u> Line <u>10</u> (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? <u>Yes</u> If NO, attach a complete explanation. (8) Are you presently operating under a sale and leaseback arrangement? <u>No</u> If YES, give effective date of lease. <u>N/A</u> (9) Are you presently operating under a sublease agreement? YES <u>X</u> NO (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO <u>X</u> If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. <u>N/A</u> (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ <u>210,246</u> 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? <u>No</u> 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? <u>Yes</u> (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? <u>No</u> 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. \$ <u>N/A</u> Has any meal income been offset against related costs? <u>No</u> Indicate the amount. \$ <u>0</u> (16) Travel and Transportation a. Are there costs included for out-of-state travel? <u>No</u> If YES, attach a complete explanation. b. Do you have a separate contract with the Department to provide medical transportation for residents? <u>No</u> If YES, please indicate the amount of income earned from such a program during this reporting period. \$ <u>N/A</u> c. What percent of all travel expense relates to transportation of nurses and patients? <u>100%</u> d. Have vehicle usage logs been maintained? <u>N/A</u> e. Are all vehicles stored at the nursing home during the night and all other times when not in use? <u>N/A</u> f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? <u>N/A</u> g. Does the facility transport residents to and from day training? <u>No</u> Indicate the amount of income earned from providing such transportation during this reporting period. \$ <u>N/A</u> (17) Has an audit been performed by an independent certified public accounting firm? <u>No</u> Firm Name: <u>N/A</u> (18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? <u>Yes</u> (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. <u>Yes</u> Attach invoices and a summary of services for all architect and appraisal fees.
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