

		FOR BHF USE					

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2006
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2006)

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 Facility ID Number: 0047233

Facility Name: Seminary Manor

Address: 2345 North Seminary Street Galesburg 61401
 Number City Zip Code

County: Knox

Telephone Number: (309) 344-1300 **Fax #** (309) 344-2473

HFS ID Number: 36-4560808001

Date of Initial License for Current Owners: 07/28/2005

Type of Ownership:

<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code <u>501 (c) (3)</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other
	<input type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other	

In the event there are further questions about this report, please contact:
Name: Ron Wilson **Telephone Number:** (309) 343-1550

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 10/01/2005 to 09/30/2006 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.

(Signed) _____ (Date) _____

Officer or Administrator of Provider (Type or Print Name) Ron Bishop

(Title) Director of Operations

(Signed) See Attached Independent Accountant's Report (Date) _____

Paid Preparer (Print Name and Title) McGladrey & Pullen, LLP
117 E. Main Street, Suite 210

(Firm Name & Address) P.O. Box 1070
Galesburg, IL 61401

(Telephone) (309)342-1175 Fax # (309)342-7816

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

Facility Name & ID Number Seminary Manor

0047233 Report Period Beginning: 10/01/2005 Ending: 09/30/2006

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 N/A

	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	121	Skilled (SNF)	121	44,165	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	121	TOTALS	121	44,165	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	8,859	19,126	4,025	32,010	8
9	SNF/PED					9
10	ICF		0			10
11	ICF/DD					11
12	SC		0			12
13	DD 16 OR LESS					13
14	TOTALS	8,859	19,126	4,025	32,010	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 72.48%

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

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

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

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

None

F. Does the facility maintain a daily midnight census? 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 08/01/05

J. Was the facility purchased or leased after January 1, 1978?

YES Date 07/28/05 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 121 and days of care provided 4,025

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 09/30/06 Fiscal Year: 09/30/06

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

Facility Name & ID Number Seminary Manor # 0047233 Report Period Beginning: 10/01/2005 Ending: 09/30/2006

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 OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	212,923	41,844	7,200	261,967		261,967		261,967			1
2	Food Purchase		244,671		244,671		244,671		244,671			2
3	Housekeeping	69,910	34,036	(50)	103,896		103,896		103,896			3
4	Laundry	45,552	23,568		69,120		69,120		69,120			4
5	Heat and Other Utilities			118,961	118,961		118,961		118,961			5
6	Maintenance	86,029	60,906	58,729	205,664		205,664		205,664			6
7	Other (specify):*											7
8	TOTAL General Services	414,414	405,025	184,840	1,004,279		1,004,279		1,004,279			8
	B. Health Care and Programs											
9	Medical Director			22,500	22,500		22,500		22,500			9
10	Nursing and Medical Records	1,343,316	263,175	1,667	1,608,158		1,608,158		1,608,158			10
10a	Therapy			261,301	261,301		261,301		261,301			10a
11	Activities	58,888	1,735	841	61,464		61,464	(620)	60,844			11
12	Social Services	21,713			21,713		21,713		21,713			12
13	CNA Training											13
14	Program Transportation			327	327	4,411	4,738		4,738			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,423,917	264,910	286,636	1,975,463	4,411	1,979,874	(620)	1,979,254			16
	C. General Administration											
17	Administrative	148,405			148,405		148,405		148,405			17
18	Directors Fees							1,854	1,854			18
19	Professional Services			179,164	179,164		179,164	923	180,087			19
20	Dues, Fees, Subscriptions & Promotions			45,400	45,400		45,400	(31,196)	14,204			20
21	Clerical & General Office Expenses	47,699	28,197	26,372	102,268		102,268	1,349	103,617			21
22	Employee Benefits & Payroll Taxes			369,647	369,647		369,647	8,120	377,767			22
23	Inservice Training & Education			363	363		363		363			23
24	Travel and Seminar			1,536	1,536		1,536	1,809	3,345			24
25	Other Admin. Staff Transportation			8,822	8,822	(4,411)	4,411	1,626	6,037			25
26	Insurance-Prop.Liab.Malpractice			57,487	57,487		57,487	104,940	162,427			26
27	Other (specify):* See Att Sch VI	16,672		62,716	79,388		79,388	(79,388)				27
28	TOTAL General Administration	212,776	28,197	751,507	992,480	(4,411)	988,069	10,037	998,106			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,051,107	698,132	1,222,983	3,972,222		3,972,222	9,417	3,981,639			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.

Facility Name & ID Number Seminary Manor #0047233 Report Period Beginning: 10/01/2005 Ending: 09/30/2006

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			13,488	13,488	13,488	275,077	288,565				30
31	Amortization of Pre-Op. & Org.											31
32	Interest						474,183	474,183				32
33	Real Estate Taxes						119,100	119,100				33
34	Rent-Facility & Grounds			830,402	830,402	830,402	(830,402)					34
35	Rent-Equipment & Vehicles			13,566	13,566	13,566		13,566				35
36	Other (specify):* See Att Sch IV						8,890	8,890				36
37	TOTAL Ownership			857,456	857,456	857,456	46,848	904,304				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			26,787	26,787	26,787		26,787				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			1,909	1,909	1,909		1,909				41
42	Provider Participation Fee			66,249	66,249	66,249		66,249				42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			94,945	94,945	94,945		94,945				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,051,107	698,132	2,175,384	4,924,623	4,924,623	56,265	4,980,888				45

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

Facility Name & ID Number Seminary Manor

0047233

Report Period Beginning: 10/01/2005

Ending: 09/30/2006

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				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		V-30		9
10	Interest and Other Investment Income	(109)	V-32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(60,221)	V-27		24
25	Fund Raising, Advertising and Promotional	(31,438)	V-20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Att Sch VII	(21,029)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (112,797)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	153,107		34
35	Other- Attach Schedule See Att Sch III	15,955		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 169,062		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ 56,265		37

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

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

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

BHF USE ONLY					
48		49		50	51
					52

Seminary Manor

ID# 0047233
 Report Period Beginning: 10/01/2005
 Ending: 09/30/2006

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

STATE OF ILLINOIS

Facility Name & ID Number Seminary Manor

0047233

Report Period Beginning:

10/01/2005 Ending:

Summary B

09/30/2006

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	153,107	0	0	0	0	0	0	0	0	0	153,107	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	0	153,107	0	153,107	37								
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	0	153,107	0	153,107	45								

Facility Name & ID Number Seminary Manor

0047233

Report Period Beginning: 10/01/2005 Ending: 09/30/2006

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached Schedule I		See Attached Schedule I		See Attached Schedule I		

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 Facility rent	\$ 830,402	Galesburg North Seminary, LLC	N/A	\$ 983,509	\$ 153,107	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		\$ 830,402			\$ 983,509	\$ * 153,107	14

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

Facility Name & ID Number Seminary Manor # 0047233 Report Period Beginning: 10/01/2005 Ending: 09/30/2006

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	See Attached Schedules II & III								\$ 1,854	18-7	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	\$ 1,854		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 Seminary Manor

0047233 Report Period Beginning: 10/01/2005

Ending: 9/30/2006

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

Name of Related Organization Unlimited Development, Inc.
 Street Address 115 East South St
 City / State / Zip Code Galesburg, IL 61401
 Phone Number (309)343-1550
 Fax Number (309)343-2857

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2	See Attached Schedule II & III							65,238	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				\$	\$		\$	65,238

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1 Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Cambridge Realty Capital		X	Facility purchase	\$47,507.82		\$ 9,180,000	\$ 9,076,885	8/1/2040	5.2000	\$ 474,292	1
2	LTD. Of Illinois											2
3												3
4												4
5												5
	Working Capital											
6	Miscellaneous											6
7												7
8	Less Interest Income										(109)	8
9	TOTAL Facility Related				\$47,507.82		\$ 9,180,000	\$ 9,076,885			\$ 474,183	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$ 9,180,000	\$ 9,076,885			\$ 474,183	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 90,937 Line # 26

* 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

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>			
1. Real Estate Tax accrual used on 2005 report.		\$ 19,900	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.)		\$ 50,755	2
3. Under or (over) accrual (line 2 minus line 1).		\$ 30,855	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 88,245	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.		\$ 119,100	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2001	N/A	8
	2002	N/A	9
	2003	N/A	10
	2004	N/A	11
	2005	117,645	12
This facility was purchased from an unrelated for-profit entity during 2005. A tax exemption has not yet been obtained. Line 2 does not agree to the current year tax bill by the difference paid/settled by the prior owner.			
Accrual is based on 2005 tax bill.			
		FOR BHF USE ONLY	
	13	FROM R. E. TAX STATEMENT FOR 2005 \$	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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Seminary Manor COUNTY Knox

FACILITY IDPH LICENSE NUMBER 0047233

CONTACT PERSON REGARDING THIS REPORT Ron Wilson

TELEPHONE (309) 343-1550 FAX #: (309) 343-2857

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2005 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 2005.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>99-02-101-005</u>	<u>Hawthorne Centre Sub Ex</u>	\$ <u> </u>	\$ <u> </u>
2. <u> </u>	<u>E50 Ft Lot 1 Blk 1</u>	\$ <u>116,034.00</u>	\$ <u>116,034.00</u>
3. <u>99-02-101-009</u>	<u>Hawthorne Centre Resub No. 5</u>	\$ <u> </u>	\$ <u> </u>
4. <u> </u>	<u>Pt Lt 6-Beg NW Cor S50'E413'</u>	\$ <u> </u>	\$ <u> </u>
5. <u> </u>	<u>N50.01'W412.84'To POB-AKA</u>	\$ <u> </u>	\$ <u> </u>
6. <u> </u>	<u>TR-6A</u>	\$ <u>1,611.00</u>	\$ <u>1,611.00</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>117,645.00</u>	\$ <u>117,645.00</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 & 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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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

Facility Name & ID Number Seminary Manor

0047233 Report Period Beginning:

10/01/2005 Ending:

09/30/2006

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 42,680 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

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

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

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

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

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

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

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

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	<u>Facility</u>	<u>4.33 acres</u>	<u>2005</u>	<u>\$ 287,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS			\$ 287,000	3

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	121		2005		\$ 9,633,067	\$ 240,827	40	\$ 240,827	\$	\$ 280,964	4
5											5
6											6
7											7
8											8
Improvement Type**											
9		Fire Door Closers		2005	3,059	170	15	170		170	9
10		Air Conditioners		2006	9,942	497	10	497		497	10
11		Electric Sign-Double Face		2006	39,915	2,661	10	2,661		2,661	11
12		Concrete		2006	6,963	155	15	155		155	12
13		Asphalt Drive		2006	7,360	307	8	307		307	13
14		Door w/ Side Windows		2006	3,103	52	15	52		52	14
15		Dining Room Addition		2006	4,501	50	15	50		50	15
16		Door Alarm		2006	3,177	26	10	26		26	16
17		Phone Modem		2006	2,906	48	5	48		48	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

*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 Seminary Manor

0047233

Report Period Beginning:

10/01/2005 Ending:

09/30/2006

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 9,713,993	\$ 244,793		\$ 244,793	\$	\$ 284,930	70

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

Facility Name & ID Number Seminary Manor # 0047233 Report Period Beginning: 10/01/2005 Ending: 09/30/2006

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 355,943	\$ 35,711	\$ 35,711	\$	5-10 yrs	\$ 41,645	71
72	Current Year Purchases	89,705	5,853	5,853		3-15 yrs	5,853	72
73	Fully Depreciated Assets							73
74	Indirect Costs Allocated (see Attached Sch III)							74
75	TOTALS	\$ 445,648	\$ 41,564	\$ 41,564	\$		\$ 47,498	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Care	2002 Ford F250	2006	\$ 21,200	\$ 2,208	\$ 2,208	\$	4 yrs	\$ 2,208	76
77										77
78										78
79										79
80	TOTALS			\$ 21,200	\$ 2,208	\$ 2,208	\$		\$ 2,208	80

E. Summary of Care-Related Assets

	1	Reference	2	Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$	10,467,841	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	288,565	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$	288,565	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$		84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$	334,636	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	2006 Toyota Corolla - 2006	\$ 14,900	\$ 1,242	\$ 1,242	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 14,900	\$ 1,242	\$ 1,242	91

G. Construction-in-Progress

	Description	Cost	
92			92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Galesburg North Seminary, LLC

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

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ <u>See Attached</u>			3
4	Additions				<u>Schedule IV - Related Party Lease</u>			4
5								5
6								6
7	TOTAL				\$			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

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

12.	<u>/2007</u>	\$ _____
13.	<u>/2008</u>	\$ _____
14.	<u>/2009</u>	\$ _____

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 N/A. N/A

9. Option to Buy: YES NO Terms: N/A*

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: \$ Amt not determined Description: _____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

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

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

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

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	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.

Facility Name & ID Number Seminary Manor# 0047233Report Period Beginning: 10/01/2005

Ending:

09/30/2006**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 09/30/2006

(last day of reporting year)

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	\$ 77,273	\$ 88,285	1
2	Cash-Patient Deposits	2,670	2,670	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>7,337</u>)	478,775	478,775	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance		63,883	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Att Sch VIII</u>	41,788	329,304	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 600,506	\$ 962,917	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		287,000	13
14	Buildings, at Historical Cost		9,633,067	14
15	Leasehold Improvements, at Historical Cost	80,926	80,926	15
16	Equipment, at Historical Cost	126,814	481,747	16
17	Accumulated Depreciation (book methods)	(13,505)	(335,878)	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>Deposit</u>	175	175	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 194,410	\$ 10,147,037	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 794,916	\$ 11,109,954	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 283,942	\$ 196,554	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	2,670	2,670	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	49,034	49,034	30
31	Accrued Taxes Payable (excluding real estate taxes)	6,279	6,279	31
32	Accrued Real Estate Taxes(Sch.IX-B)		88,245	32
33	Accrued Interest Payable		39,333	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Interdivision payable</u>	335,219	1,735,826	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 677,144	\$ 2,117,941	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		9,076,885	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44	<u>Security deposits</u>	65,530	65,530	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 65,530	\$ 9,142,415	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 742,674	\$ 11,260,356	46
47	TOTAL EQUITY (page 18, line 24)	\$ 52,242	\$ (150,402)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 794,916	\$ 11,109,954	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 31,900	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 31,900	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	20,342	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)	\$ 20,342	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)	\$ 52,242	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Seminary Manor# 0047233Report Period Beginning: 10/01/2005Ending: 09/30/2006**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	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,759,502	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,759,502	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	18,972	6
7	Oxygen	17,296	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 36,268	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	5,359	12
13	Barber and Beauty Care	4,933	13
14	Non-Patient Meals	80,132	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	2,550	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 92,974	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	109	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 109	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Att. Sch X</u>	6,829	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 6,829	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,895,682	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,004,279	31
32	Health Care	1,975,463	32
33	General Administration	943,197	33
B. Capital Expense			
34	Ownership	857,456	34
C. Ancillary Expense			
35	Special Cost Centers	28,696	35
36	Provider Participation Fee	66,249	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,875,340	40
41	Income before Income Taxes (line 30 minus line 40)**	20,342	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 20,342	43

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

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

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

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

Facility Name & ID Number Seminary Manor

0047233

Report Period Beginning: 10/01/2005

Ending:

09/30/2006

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	1,955	2,080	\$ 50,938	\$ 24.49	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,051	7,501	140,643	18.75	3
4	Licensed Practical Nurses	20,210	21,500	328,300	15.27	4
5	CNAs & Orderlies	86,021	91,512	749,484	8.19	5
6	CNA Trainees					6
7	Licensed Therapist			0		7
8	Rehab/Therapy Aides			0		8
9	Activity Director	1,624	1,728	21,803	12.62	9
10	Activity Assistants	5,282	5,619	37,085	6.60	10
11	Social Service Workers	1,855	1,974	21,713	11.00	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	25,144	26,749	212,923	7.96	15
16	Dishwashers					16
17	Maintenance Workers	7,186	7,645	86,029	11.25	17
18	Housekeepers	9,064	9,643	69,910	7.25	18
19	Laundry	6,344	6,748	45,552	6.75	19
20	Administrator	1,747	1,858	71,476	38.47	20
21	Assistant Administrator	1,856	1,975	27,646	14.00	21
22	Other Administrative	815	867	16,672	19.23	22
23	Office Manager					23
24	Clerical	4,152	4,417	47,699	10.80	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	1,955	2,080	16,637	8.00	31
32	Other Health Care(specify)	3,367	3,582	57,314	16.00	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	185,628	197,478	\$ 2,001,824 *	\$ 10.14	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	\$ 7,200	1-3	35
36	Medical Director	22,500	9-3	36
37	Medical Records Consultant	0	10-3	37
38	Nurse Consultant	0	10-3	38
39	Pharmacist Consultant	1,637	10-3	39
40	Physical Therapy Consultant	138,813	10a-3	40
41	Occupational Therapy Consultant	81,212	10a-3	41
42	Respiratory Therapy Consultant	0	10a-3	42
43	Speech Therapy Consultant	41,276	10a-3	43
44	Activity Consultant	841	11-3	44
45	Social Service Consultant	0	12-3	45
46	Other(specify) <u>Dental Consultant</u>	30	10-3	46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 293,509		49

C. CONTRACT NURSES

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

Facility Name & ID Number Seminary Manor

0047233

Report Period Beginning: 10/01/2005

Ending: 09/30/2006

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Vary Fischer	Administrator		\$ 65,511	Workers' Compensation Insurance	\$ 92,881	IDPH License Fee	\$ 0	
Tracy Ownes	Administrator		5,965	Unemployment Compensation Insurance	3,152	Advertising: Employee Recruitment	564	
Cecilee Farris	Asst. Admin.		27,646	FICA Taxes	151,574	Health Care Worker Background Check		
				Employee Health Insurance	106,295	(Indicate # of checks performed <u>382</u>)	3,820	
				Employee Meals	0	Patient Background Checks	0	
				Illinois Municipal Retirement Fund (IMRF)*	0	IHCA Dues	5,520	
Indirect costs - see Att. Sch III			49,283	401(k) Plan Contributions	7,876	Advertising - Promotion	30,184	
TOTAL (agree to Schedule V, line 17, col. 1)				Other Employee Benefits	7,449	Other Subscriptions Licenses and Fees	4,058	
(List each licensed administrator separately.)			\$ 148,405	Employee Appreciation	420	Advertising - Yellow Page	1,254	
						Indirect Costs - See Att Sch III	242	
B. Administrative - Other						Less: Public Relations Expense	()	
Description			Amount	Indirect costs - see Att. Sch III	8,120	Non-allowable advertising	(30,184)	
			\$			Yellow page advertising	(1,254)	
				TOTAL (agree to Schedule V, line 22, col.8)	\$ 377,767	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 14,204	
TOTAL (agree to Schedule V, line 17, col. 3)			\$	E. Schedule of Non-Cash Compensation Paid to Owners or Employees				
(Attach a copy of any management service agreement)				Description	Line #	Amount		
C. Professional Services							G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount				Description	Amount
RFMS, Inc.	Administrative Services		\$ 171,600				Out-of-State Travel	\$
McGladrey & Pullen	Accounting Services		7,459					
Davis & Campbell	Legal Fees		105				In-State Travel	
							Staff use of personal vehicle on facility business and meals (under \$250 per travel voucher)	0
							Seminar Expense	1,536
							Less: Non-allowable out-of-sate travel	
							Indirect costs - See Att Sch III	1,809
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	(agree to Sch. V, line 24, col. 8)	
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 179,164				TOTAL	\$ 3,345

* Attach copy of IMRF notifications

**See instructions.

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. See Page 21, Section F
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes - IHCA Dues If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 25,733 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 66,249
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ None Has any meal income been offset against related costs? Yes Indicate the amount. \$ 80,132
- (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? None
- 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? N/A
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: McGladrey & Pullen, LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Audit not yet completed
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.