

		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: 0034066

Facility Name: St Mary's Square Living Center

Address: 239 South Cherry Street Galesburg 61401
 Number City Zip Code

County: Knox

Telephone Number: (309) 343-4101 **Fax #** (309) 343-4118

HFS ID Number: 37-1223609001

Date of Initial License for Current Owners: 07/15/88

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 07/01/2005 to 06/30/2006 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.

Officer or Administrator of Provider

(Signed) _____ (Date) _____

(Type or Print Name) Bobby Dillard

(Title) Administrator

Paid Preparer

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

(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 St Mary's Square Living Center

0034066 Report Period Beginning: 07/01/2005 Ending: 06/30/2006

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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	<u>255</u>	Intermediate (ICF)	<u>255</u>	<u>93,075</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>255</u>	TOTALS	<u>255</u>	<u>93,075</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	
8	SNF				8
9	SNF/PED				9
10	ICF	<u>73,318</u>	<u>365</u>		<u>73,683</u>
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	<u>73,318</u>	<u>365</u>		<u>73,683</u>

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.17%

D. How many bed-hold days during this year were paid by the Department? 973 (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 04/01/80

J. Was the facility purchased or leased after January 1, 1978?
YES Date 07/15/88 NO

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

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 06/30/06 Fiscal Year: 6/30/06

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

Facility Name & ID Number St Mary's Square Living Center # 0034066 Report Period Beginning: 07/01/2005 Ending: 06/30/2006

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	416,728	32,037	18,000	466,765		466,765		466,765			1
2	Food Purchase		381,618		381,618	(9,520)	372,098		372,098			2
3	Housekeeping	308,209	62,314		370,523		370,523		370,523			3
4	Laundry	178,075	41,045		219,120		219,120		219,120			4
5	Heat and Other Utilities			264,971	264,971		264,971		264,971			5
6	Maintenance	161,717	57,293	68,910	287,920		287,920		287,920			6
7	Other (specify):*											7
8	TOTAL General Services	1,064,729	574,307	351,881	1,990,917	(9,520)	1,981,397		1,981,397			8
	B. Health Care and Programs											
9	Medical Director			18,600	18,600		18,600		18,600			9
10	Nursing and Medical Records	3,270,142	147,484	21,355	3,438,981		3,438,981		3,438,981			10
10a	Therapy			7,485	7,485		7,485		7,485			10a
11	Activities	85,092	11,720	50,809	147,621		147,621	(27,429)	120,192			11
12	Social Services	92,587		840	93,427		93,427		93,427			12
13	CNA Training											13
14	Program Transportation			178	178	13,013	13,191		13,191			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,447,821	159,204	99,267	3,706,292	13,013	3,719,305	(27,429)	3,691,876			16
	C. General Administration											
17	Administrative	91,279			91,279		91,279		91,279			17
18	Directors Fees			13,946	13,946		13,946		13,946			18
19	Professional Services			462,509	462,509		462,509	(25,548)	436,961			19
20	Dues, Fees, Subscriptions & Promotions			27,614	27,614		27,614	(489)	27,125			20
21	Clerical & General Office Expenses	145,604	36,735	21,135	203,474		203,474		203,474			21
22	Employee Benefits & Payroll Taxes			1,127,845	1,127,845	9,520	1,137,365		1,137,365			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,080	4,080		4,080	(3,556)	524			24
25	Other Admin. Staff Transportation			26,026	26,026	(13,013)	13,013		13,013			25
26	Insurance-Prop.Liab.Malpractice			105,104	105,104		105,104	15,078	120,182			26
27	Other (specify):* Bad Debt			8,641	8,641		8,641	(8,641)				27
28	TOTAL General Administration	236,883	36,735	1,796,900	2,070,518	(3,493)	2,067,025	(23,156)	2,043,869			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,749,433	770,246	2,248,048	7,767,727		7,767,727	(50,585)	7,717,142			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 St Mary's Square Living Center #0034066 Report Period Beginning: 07/01/2005 Ending: 06/30/2006

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 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			110,769	110,769		110,769	213,909	324,678			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							314,000	314,000			32
33	Real Estate Taxes							184,747	184,747			33
34	Rent-Facility & Grounds			846,070	846,070		846,070	(701,462)	144,608			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* See Att Sch III							38,460	38,460			36
37	TOTAL Ownership			956,839	956,839		956,839	49,654	1,006,493			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			536,488	536,488		536,488		536,488			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			536,488	536,488		536,488		536,488			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,749,433	770,246	3,741,375	9,261,054		9,261,054	(931)	9,260,123			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 St Mary's Square Living Center

0034066

Report Period Beginning: 07/01/2005

Ending: 06/30/2006

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				9
10	Interest and Other Investment Income	(41,369)	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	(8,641)	V-27		24
25	Fund Raising, Advertising and Promotional	(489)	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 Schedule IV	(56,533)	V-11		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (107,032)		\$	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)	106,101		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 106,101		36
(sum of SUBTOTALS				
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (931)		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

St Mary's Square Living Center

ID# 0034066

Report Period Beginning: 07/01/2005

Ending: 06/30/2006

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 St Mary's Square Living Center

0034066

Report Period Beginning:

07/01/2005 Ending:

Summary B

06/30/2006

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	106,101	0	0	0	0	0	0	0	0	0	106,101	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	106,101	0	106,101	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	106,101	0	106,101	45								

Facility Name & ID Number St Mary's Square Living Center

0034066

Report Period Beginning: 07/01/2005 Ending: 06/30/2006

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
Community Residential Centers, Inc. (Non profit organization)	100%			CRC Cherry Street Facility, LLC	Galesburg	Lessor

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	\$ 701,462	CRC Cherry Street Facility, LLC (Sole member is Community Residential Centers, Inc.)	N/A	\$ 807,563	\$	106,101
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		\$ 701,462			\$ 807,563	\$ *	106,101

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

Facility Name & ID Number St Mary's Square Living Center # 0034066 Report Period Beginning: 07/01/2005 Ending: 06/30/2006

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	Stanley Sydlowski, D.D.S.	President	Director	None	N/A	N/A	N/A	Board mtgs	\$ 3,000	18-3	1
2	Charles D. Westbay	Secretary	Director	None	N/A	N/A	N/A	Board mtgs	3,000	18-3	2
3	Gary Bruington	Director	Director	None	N/A	N/A	N/A	Board mtgs	3,000	18-3	3
4	Valerie Flacco	Director	Director	None	N/A	N/A	N/A	Board mtgs	3,000	18-3	4
5											5
6								Training and meeting expenses	1,946	18-3	6
7								Less: Non-allowable out-of-state travel	0	18-7	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 13,946		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 Mary's Square Living Center

0034066 Report Period Beginning: 07/01/2005

Ending: 6/30/2006

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 _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					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	GMAC Commercial						\$	\$		\$	1					
2	Mortgage Corporation		X	Facility Purchase	\$39,717.00	09/01/03	6,164,400	5,856,545	10/01/2028	6.0000	355,369	2				
3												3				
4												4				
5												5				
Working Capital																
6												6				
7	Interest Income			page 5 line 10							(41,369)	7				
8												8				
9	TOTAL Facility Related				\$39,717.00		\$ 6,164,400	\$ 5,856,545			\$ 314,000	9				
B. Non-Facility Related*																
10												10				
11												11				
12												12				
13												13				
14	TOTAL Non-Facility Related						\$	\$			\$	14				
15	TOTALS (line 9+line14)						\$ 6,164,400	\$ 5,856,545			\$ 314,000	15				

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 30,012 Line # V-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.		\$ 186,900	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.)		\$ 186,459	2																																	
3. Under or (over) accrual (line 2 minus line 1).		\$ (441)	3																																	
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 185,189	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.		\$ 184,748	7																																	
Real Estate Tax History:																																				
Real Estate Tax Bill for Calendar Year:	<table border="1"> <tr><td>2001</td><td><u>114,801</u></td><td><u>8</u></td></tr> <tr><td>2002</td><td><u>125,484</u></td><td><u>9</u></td></tr> <tr><td>2003</td><td><u>126,213</u></td><td><u>10</u></td></tr> <tr><td>2004</td><td><u>182,165</u></td><td><u>11</u></td></tr> <tr><td>2005</td><td><u>186,892</u></td><td><u>12</u></td></tr> </table>	2001	<u>114,801</u>	<u>8</u>	2002	<u>125,484</u>	<u>9</u>	2003	<u>126,213</u>	<u>10</u>	2004	<u>182,165</u>	<u>11</u>	2005	<u>186,892</u>	<u>12</u>	<table border="1"> <tr><td colspan="2">FOR BHF USE ONLY</td><td></td></tr> <tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2005</td><td>\$</td><td>13</td></tr> <tr><td>14</td><td>PLUS APPEAL COST FROM LINE 5</td><td>\$</td><td>14</td></tr> <tr><td>15</td><td>LESS REFUND FROM LINE 6</td><td>\$</td><td>15</td></tr> <tr><td>16</td><td>AMOUNT TO USE FOR RATE CALCULATION</td><td>\$</td><td>16</td></tr> </table>	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
2001	<u>114,801</u>	<u>8</u>																																		
2002	<u>125,484</u>	<u>9</u>																																		
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15	LESS REFUND FROM LINE 6	\$	15																																	
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16																																	
<p>Real estate tax accrual is based on estimated tax expense. In September 2003, related not-for-profit lessor purchased facility and is in the process of applying for real estate tax exemption.</p>																																				

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 St Mary's Square Living Center COUNTY Knox

FACILITY IDPH LICENSE NUMBER 0034066

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>9915233010</u>	<u>239 S. Cherry Galesburg, IL</u>	\$ <u>182,424.32</u>	\$ <u>182,424.32</u>
2. <u>9915233008</u>	<u>239 S. Cherry Galesburg, IL</u>	\$ <u>606.70</u>	\$ <u>606.70</u>
3. <u>9915233009</u>	<u>262 S. Prarie St. Galesburg, IL</u>	\$ <u>3,860.82</u>	\$ <u>3,860.82</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>186,891.84</u>	\$ <u>186,891.84</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 St Mary's Square Living Center

0034066 Report Period Beginning:

07/01/2005 Ending:

06/30/2006

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 131,192 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 4 and 5

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).

None

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	Facility	120,682	2003	\$ 180,000	1
2	Facility	11,210	2003	4,000	2
3	TOTALS	131,892		\$ 184,000	3

Facility Name & ID Number St Mary's Square Living Center

0034066

Report Period Beginning:

07/01/2005 Ending: 06/30/2006

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	255		2003		\$ 6,220,000	\$ 207,333	30	\$ 207,333	\$	\$ 570,166	4
5			2003		131,518	6,576	20	6,576		16,988	5
6											6
7											7
8											8
	Improvement Type**										
9											9
10		Garage addition, sidewalk, furnace, elevator		1988	46,740	781	15-20	781		45,152	10
11		Sprinkler, roof repair		1989	29,422	1,455	20-25	1,455		24,299	11
12		Water chiller repair, boiler repair		1990	11,633	423	15-20	423		10,155	12
13		Roof repair, roofing		1991	49,477	2,474	20	2,474		38,010	13
14		Heater/furnace		1992	2,505	167	15	167		2,282	14
15		Windows, sidewalk		1993	7,150	476	15	476		6,234	15
16		Paving, plumbing, boiler equipment, roofing		1994	30,695	1,670	10 to 20	1,670		23,661	16
17		A/C Chiller, tuckpoint, roofing, transformer, elevator equip,		1995	102,052	4,771	15 to 25	4,771		50,949	17
18		Alarm electric work, water heater, door closers, A/C units, stucco work		1996	62,518	3,699	10 to 25	3,699		40,536	18
19		A/C units, fire alarm system, paving		1997	62,969	3,667	8 to 15	3,667		59,264	19
20		Fire alarm, paving, condensate ret. System		1998	16,340	1,546	8 to 15	1,546		13,492	20
21		Coils & stats, fire alarm, commercial door		1999	62,346	6,101	10 to 15	6,101		41,634	21
22		Kitchen upgrade, air conditioner rep, countertop, hall handle rep, HVAC		2000	30,547	2,332	10 to 15	2,332		14,062	22
23		Patio, Elevator renovation		2002	77,220	3,861	20	3,861		14,421	23
24		Air handler		2003	22,100	1,105	20	1,105		3,499	24
25		Concrete construction		2003	12,300	615	20	615		1,896	25
26		Vinyl flooring		2003	3,610	361	10	361		1,083	26
27		Patio construction		2003	8,614	574	15	574		1,627	27
28		Canopy		2004	9,494	633	15	633		1,424	28
29		Entry remodeling		2004	47,112	3,141	15	3,141		7,329	29
30		Ceramic flooring		2004	23,779	1,189	20	1,189		2,576	30
31		Wallcoverings		2004	2,898	580	5	580		1,208	31
32		Kitchen tray slide		2004	5,143	343	15	343		829	32
33		Fire sprinkler upgrade-entry		2004	3,390	136	25	136		283	33
34		Low E windows		2004	2,591	173	15	173		360	34
35		Window Awning		2004	920	61	15	61		128	35
36		Water Heater		2005	4,632	463	10	463		579	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number St Mary's Square Living Center

0034066

Report Period Beginning:

07/01/2005 Ending: 06/30/2006

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Hi low manifold system	2005	\$ 1,559	\$ 156	10	\$ 156	\$	\$ 195	37
38	Fire alarm system upgrade	2005	8,304	830	10	830		899	38
39	Lounge wiring, plumbing, HVAC	2004	31,730	1,587	20	1,587		3,174	39
40	Entryway flashing	2004	1,224	122	10	122		234	40
41	Chiller coil replacement	2004	8,250	550	15	550		1,054	41
42	Boiler piping	2004	4,873	244	20	244		386	42
43	Water heater, wiring and plumbing	2004	9,225	923	10	923		1,461	43
44	Carpet	2004	978	196	5	196		392	44
45	Water Heater	2004	3,750	375	10	375		719	45
46	Elevator hydraulic piston replacement	2004	16,595	830	20	830		1,314	46
47	Tile installation (vinyl)	2005	2,000	200	10	200		283	47
48	Canopy carpentry	2004	16,967	1,131	15	1,131		2,262	48
49	Canopy	2004	21,168	1,411	15	1,411		2,587	49
50	Vinyl flooring	2004	15,754	1,575	10	1,575		2,888	50
51	Front entryway	2004	126,978	8,465	15	8,465		14,814	51
52	Painting	2004	2,944	589	5	589		1,080	52
53	Painting	2004	2,128	426	5	426		745	53
54	Door closers	2004	2,276	228	10	228		380	54
55	Fire alarm system	2005	22,679	2,268	10	2,268		2,268	55
56	Sprinkler system	2006	25,839	143	15	143		143	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)		\$ 7,414,936	\$ 278,955		\$ 278,955	\$	\$ 1,031,404	70

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

Facility Name & ID Number St Mary's Square Living Center # 0034066 Report Period Beginning: 07/01/2005 Ending: 06/30/2006

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	\$ 568,023	\$ 28,645	\$ 28,645	\$	5-20 yrs	\$ 428,104	71
72	Current Year Purchases	53,013	4,266	4,266		7-15 yrs	4,266	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 621,036	\$ 32,911	\$ 32,911	\$		\$ 432,370	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	See Attached Schedule I	See Attached Schedule I	See Attached Schedule I	\$ 201,024	\$ 12,812	\$ 12,812	\$	4 yrs	\$ 172,664	76
77										77
78										78
79										79
80	TOTALS			\$ 201,024	\$ 12,812	\$ 12,812	\$		\$ 172,664	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)	\$ 8,420,996	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 324,678	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 324,678	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)	\$ 1,636,438	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		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	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.

Facility Name & ID Number St Mary's Square Living Center

0034066

Report Period Beginning: 07/01/2005

Ending: 06/30/2006

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A Related Party Lease

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

If NO, see instructions.

YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

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.	/2007	\$	
13.	/2008	\$	
14.	/2009	\$	

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

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: \$ N/A Description: N/A

(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 checked="" type="checkbox"/> YES <input 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. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA <u>140</u></p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	--	---

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)		65,657		65,657
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 65,657	\$	\$ 65,657
10	SUM OF line 9, col. 1 and 2 (e)	\$	65,657		

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	41
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	41

- (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	5 Units 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 St Mary's Square Living Center# 0034066Report Period Beginning: 07/01/2005

Ending:

06/30/2006

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/2006

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 737,817	\$ 756,649	1
2	Cash-Patient Deposits	11,850	11,850	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>10,000</u>)	1,349,964	1,349,964	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	41,159	48,499	6
7	Other Prepaid Expenses	1,418	1,418	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Att Schedule VI</u>	6,706,377	6,706,377	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 8,848,585	\$ 8,874,757	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	931,208	931,208	12
13	Land		184,000	13
14	Buildings, at Historical Cost		6,351,518	14
15	Leasehold Improvements, at Historical Cost	1,063,418	1,063,418	15
16	Equipment, at Historical Cost	822,060	822,060	16
17	Accumulated Depreciation (book methods)	(1,049,284)	(1,636,438)	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>See Att Schedule V</u>		1,121,529	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,767,402	\$ 8,837,295	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 10,615,987	\$ 17,712,052	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 213,489	\$ 213,489	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	11,850	11,850	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	297,243	297,243	30
31	Accrued Taxes Payable (excluding real estate taxes)	14,690	199,879	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable		29,889	33
34	Deferred Compensation	11,382	11,382	34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Accrued Health Assessment</u>	51,511	51,511	36
37	<u>Attached Schedule VII</u>	573,802	609,332	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,173,967	\$ 1,424,575	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,856,545	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)	\$	\$ 5,856,545	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,173,967	\$ 7,281,120	46
47	TOTAL EQUITY(page 18, line 24)	\$ 9,442,020	\$ 10,430,932	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 10,615,987	\$ 17,712,052	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 9,832,747	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 9,832,747	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(344,208)	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) <u>Unrealized loss on investments</u>	(46,519)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (390,727)	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)	\$ 9,442,020	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number St Mary's Square Living Center# 0034066Report Period Beginning: 07/01/2005Ending: 06/30/2006**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	\$ 8,737,610	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,737,610	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	65,657	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		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)	\$ 65,657	23
D. Non-Operating Revenue			
24	Contributions	44,781	24
25	Interest and Other Investment Income***	41,369	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 86,150	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Activity Fund Income	27,429	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 27,429	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,916,846	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,990,917	31
32	Health Care	3,706,292	32
33	General Administration	2,070,518	33
B. Capital Expense			
34	Ownership	956,839	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	536,488	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,261,054	40
41	Income before Income Taxes (line 30 minus line 40)**	(344,208)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (344,208)	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 St Mary's Square Living Center

0034066

Report Period Beginning: 07/01/2005

Ending:

06/30/2006

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	1,956	2,080	\$ 45,944	\$ 22.09	1
2	Assistant Director of Nursing	899	956	14,251	14.91	2
3	Registered Nurses	5,006	5,325	101,335	19.03	3
4	Licensed Practical Nurses	27,342	29,087	451,434	15.52	4
5	CNAs & Orderlies	203,978	219,332	2,116,550	9.65	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	6,298	6,700	85,092	12.70	9
10	Activity Assistants					10
11	Social Service Workers	6,783	7,216	92,587	12.83	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	40,053	42,610	416,728	9.78	15
16	Dishwashers					16
17	Maintenance Workers	10,865	11,559	161,717	13.99	17
18	Housekeepers	29,088	30,945	308,209	9.96	18
19	Laundry	15,217	16,189	178,075	11.00	19
20	Administrator	1,932	2,080	79,839	38.38	20
21	Assistant Administrator					21
22	Other Administrative	377	397	11,440	28.82	22
23	Office Manager					23
24	Clerical	12,603	13,407	145,604	10.86	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	37,325	39,708	513,024	12.92	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,972	3,162	27,604	8.73	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	402,694	430,753	\$ 4,749,433 *	\$ 11.03	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	***	\$ 18,000	1-3	35
36	Medical Director	***	18,600	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	***	2,484	10-3	39
40	Physical Therapy Consultant	***	1,155	10a-3	40
41	Occupational Therapy Consultant	***	1,995	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	***	4,335	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant	***	840	12-3	45
46	Other(specify) <u>Dental Consultant</u>	***	6,265	10-3	46
47	<u>Psychological consultant</u>	***	12,606	10-3	47
48	<u>*** monthly fee</u>				48
49	TOTAL (lines 35 - 48)		\$ 66,280		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 St Mary's Square Living Center

0034066

Report Period Beginning: 07/01/2005

Ending: 06/30/2006

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	
Bobby Dillard	Administrator	None	\$ 79,839	Workers' Compensation Insurance	\$ 184,680	IDPH License Fee	\$ 0	
Bradley Van Beuning	Admissions	None	11,440	Unemployment Compensation Insurance	9,484	Advertising: Employee Recruitment	16,524	
				FICA Taxes	359,043	Health Care Worker Background Check		
				Employee Health Insurance	513,324	(Indicate # of checks performed <u>298</u>)	2,980	
				Employee Meals	9,520	Patient Background Checks	0	
				Illinois Municipal Retirement Fund (IMRF)*	0	Subscriptions	6,911	
				401 (k)	41,932	IHCA Dues	0	
				Other Employee Benefits	19,382	Advertising- Promotion	489	
						Other Licenses and Fees	710	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 91,279			Less: Public Relations Expense	()	
(List each licensed administrator separately.)						Non-allowable advertising	(489)	
						Yellow page advertising	()	
B. Administrative - Other								
Description			Amount			TOTAL (agree to Sch. V, line 20, col. 8)		
			\$		\$ 1,137,365	\$ 27,125		
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	G. Schedule of Travel and Seminar**	
C. Professional Services							Description	
Vendor/Payee	Type	Amount					Amount	
RFMS, Inc	Administrative Services	\$ 279,510					Out-of-State Travel	
RSM McGladrey, Inc.	Tax Services	6,250					\$	
McGladrey & Pullen, LLP	Accounting Services	91,350						
Davis & Campbell, LLC	Legal Fees	2,593						
Crain, Miller & Associates	Legal Fees	27,567					In-State Travel	
Schiff Hardin, LLP	Legal Fees	5,512					Staff use of personal vehicle on facility	
Foley & Lardner, LLP	Legal Fees	22,827					business and meals (under \$250 per	
Legat Architects	Architect Fees	26,900					travel voucher)	
							Seminar Expense	
							4,080	
							Less: non-allowable out of state travel	
							(3,556)	
							Entertainment Expense	
							()	
TOTAL (agree to Schedule V, line 19, column 3)			\$ 462,509	TOTAL			(agree to Sch. V, line 24, col. 8)	
(If total legal fees exceed \$5,000, attach copy of invoices.)							\$ 524	

* Attach copy of IMRF notifications

**See instructions.

