

		FOR BHF USE					

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**2007**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2007)**

IMPORTANT NOTICE  
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

**I. IDPH License ID Number:** 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:** 7/15/88

**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
<b>IRS Exemption Code</b> <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 07/01/06 to 06/30/07 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) See 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: 07/01/06 Ending: 06/30/07

## 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>75,798</u>	<u>396</u>		<u>76,194</u>
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	<u>75,798</u>	<u>396</u>		<u>76,194</u>

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.86%

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

949 (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)

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

G. Do pages 3 &amp; 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: 06/30/07 Fiscal Year: 06/30/07

\* 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: 07/01/06 Ending: 06/30/07

**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	406,119	39,740	10,287	456,146		456,146	456,146			1
2	Food Purchase		389,864		389,864	(9,967)	379,897	379,897			2
3	Housekeeping	330,858	50,848		381,706		381,706	381,706			3
4	Laundry	197,053	44,217		241,270		241,270	241,270			4
5	Heat and Other Utilities			269,075	269,075		269,075	269,075			5
6	Maintenance	175,203	73,043	72,730	320,976		320,976	320,976			6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	<b>1,109,233</b>	<b>597,712</b>	<b>352,092</b>	<b>2,059,037</b>	<b>(9,967)</b>	<b>2,049,070</b>	<b>2,049,070</b>			<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			18,600	18,600		18,600	18,600			9
10	Nursing and Medical Records	3,584,920	141,741	14,091	3,740,752		3,740,752	3,740,752			10
10a	Therapy			9,255	9,255		9,255	9,255			10a
11	Activities	95,519	11,581	53,704	160,804		160,804	160,804			11
12	Social Services	96,283		860	97,143		97,143	97,143			12
13	CNA Training										13
14	Program Transportation			190	190	14,911	15,101	15,101			14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>3,776,722</b>	<b>153,322</b>	<b>96,700</b>	<b>4,026,744</b>	<b>14,911</b>	<b>4,041,655</b>	<b>4,041,655</b>			<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	159,294			159,294		159,294	159,294			17
18	Directors Fees			9,200	9,200		9,200	9,200			18
19	Professional Services			427,707	427,707		427,707	(23,668)	404,039		19
20	Dues, Fees, Subscriptions & Promotions			16,723	16,723		16,723	(5,646)	11,077		20
21	Clerical & General Office Expenses	155,287	40,108	13,354	208,749		208,749	208,749			21
22	Employee Benefits & Payroll Taxes			1,213,112	1,213,112	9,967	1,223,079	1,223,079			22
23	Inservice Training & Education			4,006	4,006		4,006	(600)	3,406		23
24	Travel and Seminar			5,376	5,376		5,376	(5,376)			24
25	Other Admin. Staff Transportation			29,822	29,822	(14,911)	14,911	14,911			25
26	Insurance-Prop.Liab.Malpractice			45,519	45,519		45,519	14,376	59,895		26
27	Other (specify):* <b>Bad Debt expense</b>			2,386	2,386		2,386	(2,386)			27
28	<b>TOTAL General Administration</b>	<b>314,581</b>	<b>40,108</b>	<b>1,767,205</b>	<b>2,121,894</b>	<b>(4,944)</b>	<b>2,116,950</b>	<b>(23,300)</b>	<b>2,093,650</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>5,200,536</b>	<b>791,142</b>	<b>2,215,997</b>	<b>8,207,675</b>		<b>8,207,675</b>	<b>(23,300)</b>	<b>8,184,375</b>		<b>29</b>

\*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: 07/01/06 Ending: 06/30/07

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			111,666	111,666		111,666	213,910	325,576			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			4,651	4,651		4,651	309,415	314,066			32
33	Real Estate Taxes							191,017	191,017			33
34	Rent-Facility & Grounds			812,624	812,624		812,624	(812,624)				34
35	Rent-Equipment & Vehicles			48	48		48		48			35
36	Other (specify):* <a href="#">See Att Sch III</a>							37,328	37,328			36
37	<b>TOTAL Ownership</b>			928,989	928,989		928,989	(60,954)	868,035			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
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			526,644	526,644		526,644		526,644			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			526,644	526,644		526,644		526,644			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	5,200,536	791,142	3,671,630	9,663,308		9,663,308	(84,254)	9,579,054			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: 07/01/06

Ending: 06/30/07

**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	BHF 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	(38,475)	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	(2,386)	V-27		24
25	Fund Raising, Advertising and Promotional	(5,646)	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	(29,644)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (76,151)		\$	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)	(8,103)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (8,103)		36
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ (84,254)		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY					
48		49		50	51
					52

St Mary's Square Living Center

ID# 0034066

Report Period Beginning: 07/01/06

Ending: 06/30/07

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	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	<b>Total</b>	0	49



STATE OF ILLINOIS

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

# 0034066

Report Period Beginning:

07/01/06 Ending:

Summary B

06/30/07

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	(8,103)	0	0	0	0	0	0	0	0	0	(8,103)	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	<b>TOTAL Ownership</b>	<b>0</b>	<b>(8,103)</b>	<b>0</b>	<b>(8,103)</b>	<b>37</b>								
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> <b>(sum of lines 29, 37 &amp; 44)</b>	<b>0</b>	<b>(8,103)</b>	<b>0</b>	<b>(8,103)</b>	<b>45</b>								

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

# 0034066

Report Period Beginning:

07/01/06

Ending:

06/30/07

**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	\$ 812,624	CRC Cherry Street Facility, LLC (sole member is Community Residential Centers, Inc.)	N/A	\$ 804,521	\$ (8,103)	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		\$ 812,624			\$ 804,521	\$ * (8,103)	14

\* 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: 07/01/06 Ending: 06/30/07

## 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	\$ 2,000	18-3	1
2	Charles D. Westbay	Secretary	Director	None	N/A	N/A	N/A	Board mtgs	2,000	18-3	2
3	Gary Bruington	Director	Director	None	N/A	N/A	N/A	Board mtgs	2,000	18-3	3
4	Valerie Flacco	Director	Director	None	N/A	N/A	N/A	Board mtgs	2,000	18-3	4
5	David Beversdorf	Director	Director	None	N/A	N/A	N/A	Board mtgs	1,000	18-3	5
6											6
7								Training and meeting expenses	200	18-3	7
8								Less: Non-allowable out-of-state travel		18-7	8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 9,200		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:

07/01/06

Ending: 06/30/07

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**					Purpose of Loan	Monthly Payment Required				Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
<b>A. Directly Facility Related</b>																	
<b>Long-Term</b>																	
1	GMAC Commercial						\$	\$		\$	1						
2	Mortgage Corp		X	Facility purchase	\$39,717.00	9/1/2003	6,164,400	5,727,829	10/01/2028	6.0000	347,890	2					
3												3					
4												4					
5												5					
<b>Working Capital</b>																	
6												6					
7	Interest Income			page 5 line 10							(38,475)	7					
8	Misc Operating		X								4,651	8					
9	<b>TOTAL Facility Related</b>				\$39,717.00		\$ 6,164,400	\$ 5,727,829			\$ 314,066	9					
<b>B. Non-Facility Related*</b>																	
10												10					
11												11					
12												12					
13												13					
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14					
15	<b>TOTALS (line 9+line14)</b>						\$ 6,164,400	\$ 5,727,829			\$ 314,066	15					

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 28,880 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.)

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

# 0034066 Report Period Beginning: 07/01/06

Ending: 06/30/07

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

<p><b>Important</b>, 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 2006 report.		\$ <b>185,189</b>	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.)		\$ <b>187,206</b>	2
3. Under or (over) accrual (line 2 minus line 1).		\$ <b>2,017</b>	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ <b>189,000</b>	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ <b>191,017</b>	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2002	<u>125,484</u>	<u>8</u>
	2003	<u>126,213</u>	<u>9</u>
	2004	<u>182,165</u>	<u>10</u>
	2005	<u>186,892</u>	<u>11</u>
	2006	<u>187,507</u>	<u>12</u>
<b>The real estate tax accrual is based on the most current tax bill. The real estate taxes paid during the current year relate to the 2nd installment for 2005 for 2 of the 3 tax bills and the 1st installment for 2006 for 2 tax bills and the entire amount due for the 3rd tax bill.</b>			

	<b>FOR BHF USE ONLY</b>		
13	FROM R. E. TAX STATEMENT FOR 2006	\$	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:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

**2006 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 2006 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 2006.

(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>9915233009</u>	<u>262 S Cherry St Galesburg IL</u>	\$ <u>3,873.52</u>	\$ <u>3,873.52</u>
2. <u>9915233010</u>	<u>239 S Cherry St Galesburg IL</u>	\$ <u>183,024.42</u>	\$ <u>183,024.42</u>
3. <u>9915233008</u>	<u>239 S Cherry St Galesburg IL</u>	\$ <u>608.70</u>	\$ <u>608.70</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>187,506.64</u>	\$ <u>187,506.64</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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

**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:

07/01/06 Ending:

06/30/07

**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	<u>Facility</u>	<u>120,682</u>	<u>2003</u>	<u>\$ 180,000</u>	<u>1</u>
2	<u>Facility</u>	<u>11,210</u>	<u>2003</u>	<u>4,000</u>	<u>2</u>
3	<b>TOTALS</b>	<b>131,892</b>		<b>\$ 184,000</b>	<b>3</b>

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

# 0034066

Report Period Beginning:

07/01/06

Ending:

06/30/07

**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	\$ 207,334	30	\$ 207,334	\$	\$ 777,500	4
5			2003		131,518	6,576	20	6,576		23,564	5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9		Garage addition, sidewalk, furnace, elevator		1988	46,740	781	15-20	781		45,933	9
10		Sprinkler, roof repair		1989	29,422	1,455	20-25	1,455		25,754	10
11		Water chiller repair, boiler repair		1990	11,633	403	15-20	403		10,558	11
12		Roof repair, roofing		1991	49,477	2,474	20	2,474		40,484	12
13		Heater, furnace		1992	2,505	167	15	167		2,449	13
14		Windows, sidewalk		1993	7,150	476	15	476		6,710	14
15		Paving, plumbing, boiler equipment, roofing		1994	30,695	1,670	10 to 20	1,670		25,331	15
16		A/C Chiller, tuckpoint, roofing, transformer, elevator equip		1995	102,052	4,771	15-25	4,771		55,720	16
17		Alarm electric work, water heater, door closers, A/C units, stucco work		1996	62,518	2,633	10 to 25	2,633		43,169	17
18		A/C units, fire alarm system, paving		1997	62,969	1,090	8 to 15	1,090		60,354	18
19		Fire alarm, paving, condensate ret. System		1998	16,340	903	8 to 15	903		14,395	19
20		Coils & stats, fire alarm, commercial door		1999	62,346	6,101	10 to 15	6,101		47,735	20
21		Kitchen upgrade, air conditioner rep, countertop, hall handle rep, HVAC		2000	30,547	2,332	10 to 15	2,332		16,394	21
22		Patio, Elevator renovation		2002	77,220	3,861	20	3,861		18,282	22
23		Air handler		2003	22,100	1,105	20	1,105		4,604	23
24		Concrete construction		2003	12,300	615	20	615		2,511	24
25		Vinyl flooring		2003	3,610	361	10	361		1,444	25
26		Patio construction		2003	8,614	574	15	574		2,201	26
27		Canopy		2004	9,494	633	15	633		2,057	27
28		Entry remodeling		2004	47,112	3,141	15	3,141		10,470	28
29		Ceramic flooring		2004	23,779	1,189	20	1,189		3,765	29
30		Wallcoverings		2004	2,898	580	5	580		1,788	30
31		Kitchen tray slide		2004	5,143	343	15	343		1,172	31
32		Fire sprinkler upgrade-entry		2004	3,390	136	25	136		419	32
33		Low E window		2004	2,591	173	15	173		533	33
34		Window awning		2004	920	61	15	61		189	34
35		Water heater		2005	4,632	463	10	463		1,042	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 &amp; ID Number St Mary's Square Living Center

# 0034066

Report Period Beginning:

07/01/06

Ending:

06/30/07

**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	High low manifold system	2005	\$ 1,559	\$ 39	10	\$ 39	\$	\$ 234	37
38	Fire alarm system upgrade	2005	8,304	830	10	830		1,729	38
39	Lounge wiring, plumbing, HVAC	2004	31,730	1,587	20	1,587		4,761	39
40	Entryway flashing	2004	1,224	122	10	122		356	40
41	Chiller coil replacement	2004	8,250	550	15	550		1,604	41
42	Boiler piping	2004	4,873	244	20	244		630	42
43	Water heater, wiring, and plumbing	2004	9,225	923	10	923		2,384	43
44	Carpet	2004	978	196	5	196		588	44
45	Water heater, wiring, and plumbing	2004	3,750	375	10	375		1,094	45
46									46
47									47
48	Elevator hydraulic piston replacement	2004	16,595	830	20	830		2,144	48
49	Tile installation (vinyl)	2005	2,000	200	10	200		483	49
50	Canopy carpentry	2004	16,967	1,131	15	1,131		3,393	50
51	Canopy	2004	21,168	1,411	15	1,411		3,998	51
52	Vinyl flooring	2004	15,754	1,575	10	1,575		4,463	52
53	Front entryway	2004	126,978	8,465	15	8,465		23,279	53
54	Painting	2004	2,944	589	5	589		1,669	54
55	Painting	2004	2,128	426	5	426		1,171	55
56	Door closers	2004	2,276	228	10	228		608	56
57	Fire alarm system	2005	22,679	2,268	10	2,268		4,536	57
58	Sprinkler system	2006	25,839	1,722	15	1,722		1,865	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	\$ 276,112		\$ 276,112	\$	\$ 1,307,516	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: 07/01/06 Ending: 06/30/07

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	\$ 621,036	\$ 33,792	\$ 33,792	\$	5-20 yrs	\$ 466,162	71
72	Current Year Purchases	33,090	2,860	2,860		3-15 yrs	2,860	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 654,126	\$ 36,652	\$ 36,652	\$		\$ 469,022	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	\$ 185,476	76
77										77
78										78
79										79
80	TOTALS			\$ 201,024	\$ 12,812	\$ 12,812	\$		\$ 185,476	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)	\$ 8,454,086	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 325,576	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 325,576	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)	\$ 1,962,014	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	Building Remodel	\$ 90,541	92
93			93
94			94
95		\$ 90,541	95

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

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

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: N/A 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	<b>TOTAL</b>				\$			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>      /2008      </u>	\$ _____
13.	<u>      /2009      </u>	\$ _____
14.	<u>      /2010      </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

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	<b>TOTAL</b>		\$	\$	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.

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

**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. <u>CLASSROOM PORTION:</u></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>130</u></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>
--	---	--

**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)		41,075		41,075
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 41,075	\$	\$ 41,075
10	SUM OF line 9, col. 1 and 2 (e)	\$	41,075		

**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	23
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	<b>23</b>

- (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		3		4		5		6		7		8	
			Staff		Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)					
			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 prescripts													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: 07/01/06

Ending:

06/30/07

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/07

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 1,069,076	\$ 1,080,859	1
2	Cash-Patient Deposits	11,850	11,850	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>25,000</u> )	1,370,036	1,370,036	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	23,161	42,439	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached VI</u>	115,580	115,580	9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 2,589,703	\$ 2,620,764	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			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	855,150	855,150	16
17	Accumulated Depreciation (book methods)	(1,160,950)	(1,962,014)	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 (spe CIP )	90,541	90,541	22
23	Other(specify): <u>See Attached Sch V</u>		1,191,260	23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 848,159	\$ 7,773,873	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 3,437,862	\$ 10,394,637	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 116,640	\$ 116,640	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	533,862	533,862	30
31	Accrued Taxes Payable (excluding real estate taxes)	10,685	10,685	31
32	Accrued Real Estate Taxes(Sch.IX-B)		189,000	32
33	Accrued Interest Payable		29,889	33
34	Deferred Compensation	13,043	13,043	34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Accr Health Ins Assessment</u>	196,500	196,500	36
37	<u>See Attached Sch VII</u>		115,580	37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 882,580	\$ 1,217,049	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,727,829	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$	\$ 5,727,829	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 882,580	\$ 6,944,878	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 2,555,282	\$ 3,449,759	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 3,437,862	\$ 10,394,637	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 9,442,020	1
2	Restatements (describe):		2
3	Adj prop ins exp after to filing cost report	13,412	3
4	Adj allowance for dbtful accts after filing cost report	(15,000)	4
5	Adj rent expense after filing cost report	90,353	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 9,530,785	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	(288,804)	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 gain(loss) on investments</u>	14,800	15
16	Other (describe) <u>See attached explanation</u>	(6,701,499)	16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (6,975,503)	17
<b>B. Transfers (Itemize):</b>			
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)	\$ 2,555,282	24 *

\* This must agree with page 17, line 47.

Facility Name & ID Number St Mary's Square Living Center# 0034066Report Period Beginning: 07/01/06Ending: 06/30/07**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 9,246,214	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 9,246,214	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	41,075	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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 41,075	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	21,397	24
25	Interest and Other Investment Income***	38,475	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 59,872	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>	27,343	27
28	<b>Activity Fund income</b>		28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 27,343	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 9,374,504	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	2,059,037	31
32	Health Care	4,026,744	32
33	General Administration	2,121,894	33
<b>B. Capital Expense</b>			
34	Ownership	928,989	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers		35
36	Provider Participation Fee	526,644	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 9,663,308	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(288,804)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (288,804)	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: 07/01/06

Ending: 06/30/07

**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	1,837	1,976	\$ 51,367	\$ 26.00	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,664	5,015	95,437	19.03	3
4	Licensed Practical Nurses	35,191	37,840	583,110	15.41	4
5	CNAs & Orderlies	228,990	246,226	2,289,900	9.30	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	6,995	7,521	95,519	12.70	9
10	Activity Assistants					10
11	Social Service Workers	6,979	7,505	96,283	12.83	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	42,200	45,376	406,119	8.95	15
16	Dishwashers					16
17	Maintenance Workers	11,647	12,523	175,203	13.99	17
18	Housekeepers	32,944	35,424	330,858	9.34	18
19	Laundry	18,991	20,420	197,053	9.65	19
20	Administrator	1,934	2,080	88,944	42.76	20
21	Assistant Administrator					21
22	Other Administrative	1,980	2,080	70,350	33.82	22
23	Office Manager					23
24	Clerical	13,950	15,000	155,287	10.35	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	37,852	40,701	537,257	13.20	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,113	3,347	27,849	8.32	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	449,267	483,034	\$ 5,200,536 *	\$ 10.77	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	\$ 10,287	1-3	35
36	Medical Director	18,600	9-3	36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant		10-3	39
40	Physical Therapy Consultant	1,725	10a-3	40
41	Occupational Therapy Consultant	3,180	10a-3	41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant	4,350	10a-3	43
44	Activity Consultant			44
45	Social Service Consultant	860	12-3	45
46	Other(specify) <u>Dental Consultant</u>	1,138	10--3	46
47	<u>Psychological consultant</u>	12,953	10-3	47
48				48
49	TOTAL (lines 35 - 48)	\$ 53,093		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: 07/01/06

Ending: 06/30/07

**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	\$ 88,944	Workers' Compensation Insurance	\$ 152,012	IDPH License Fee	\$ 0	
Bradley Van Beuning	Admissions	None	70,350	Unemployment Compensation Insurance	10,394	Advertising: Employee Recruitment	2,740	
				FICA Taxes	372,146	Health Care Worker Background Check		
				Employee Health Insurance	595,052	(Indicate # of checks performed <u>100</u> )	1,060	
				Employee Meals	9,967	Patient Background Checks	0	
				Illinois Municipal Retirement Fund (IMRF)*	0	Subscriptions	6,733	
				401(k)	45,177	Advertising - Promotion	5,646	
				Other Employee Benefits	38,331	Other Licenses and Fees	544	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 159,294					
B. Administrative - Other								
Description			Amount					
			\$			Less: Public Relations Expense	( )	
						Non-allowable advertising	(5,646)	
						Yellow page advertising	( )	
				TOTAL (agree to Schedule V, line 22, col.8)	\$ 1,223,079	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 11,077	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	E. Schedule of Non-Cash Compensation Paid to Owners or Employees				
C. Professional Services				Description	Line #	Amount	G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount				Description	Amount
RFMS Inc	Administrative Services		\$ 279,510				Out-of-State Travel	\$
RSM McGladrey Inc.	Tax Services		12,940					
McGladrey & Pullen LLP	Accounting Services		104,673				In-State Travel	
Davis & Campbell LLC	Legal fees		260					
Crain, Miller & Associates	Legal fees		14,829				Seminar Expense	5,376
Foley & Lardner LLP	Legal fees		13,997				Less:Non-allowable out-of-state travel	(5,376)
DLA Piper US LLP	Legal fees		1,411					
Springfield Blueprints	Blueprint services		87				Entertainment Expense	( )
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 427,707	TOTAL		\$	TOTAL	\$

\* Attach copy of IMRF notifications

\*\*See instructions.



