



Facility Name & ID Number Seminary Manor

# 0047233 Report Period Beginning: 10/01/07 Ending: 9/30/08

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	<u>121</u>	Skilled (SNF)	<u>121</u>	<u>44,286</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>121</u>	TOTALS	<u>121</u>	<u>44,286</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>12,176</u>	<u>16,998</u>	<u>8,141</u>	<u>37,315</u>	8
9	SNF/PED					9
10	ICF		<u>0</u>			10
11	ICF/DD					11
12	SC		<u>0</u>			12
13	DD 16 OR LESS					13
14	TOTALS	<u>12,176</u>	<u>16,998</u>	<u>8,141</u>	<u>37,315</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.26%

D. How many bed-hold days during this year were paid by the Department? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)  
None

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

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

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

I. On what date did you start providing long term care at this location?  
Date started 08/01/05

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 07/28/05 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 121 and days of care provided 8,141

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 09/30/08 Fiscal Year: 09/30/08

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

Facility Name & ID Number Seminary Manor # 0047233 Report Period Beginning: 10/01/07 Ending: 9/30/08

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	254,347	51,116	8,865	314,328		314,328	314,328			1
2	Food Purchase		321,971		321,971		321,971	321,971			2
3	Housekeeping	113,832	39,063		152,895		152,895	152,895			3
4	Laundry	48,757	24,640		73,397		73,397	73,397			4
5	Heat and Other Utilities			166,699	166,699		166,699	166,699			5
6	Maintenance	63,743	80,623	76,626	220,992		220,992	220,992			6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	<b>480,679</b>	<b>517,413</b>	<b>252,190</b>	<b>1,250,282</b>		<b>1,250,282</b>	<b>1,250,282</b>			<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			32,226	32,226		32,226	32,226			9
10	Nursing and Medical Records	1,816,043	485,726	1,500	2,303,269		2,303,269	2,303,269			10
10a	Therapy			590,282	590,282		590,282	590,282			10a
11	Activities	59,597	7,557		67,154		67,154	(3,306)	63,848		11
12	Social Services	36,442			36,442		36,442		36,442		12
13	CNA Training										13
14	Program Transportation			4,697	4,697	4,974	9,671		9,671		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>1,912,082</b>	<b>493,283</b>	<b>628,705</b>	<b>3,034,070</b>	<b>4,974</b>	<b>3,039,044</b>	<b>(3,306)</b>	<b>3,035,738</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	171,563			171,563		171,563		171,563		17
18	Directors Fees							3,375	3,375		18
19	Professional Services			327,915	327,915		327,915	2,671	330,586		19
20	Dues, Fees, Subscriptions & Promotions			94,627	94,627		94,627	(81,702)	12,925		20
21	Clerical & General Office Expenses	66,886	38,348	38,703	143,937		143,937		143,937		21
22	Employee Benefits & Payroll Taxes			397,876	397,876		397,876		397,876		22
23	Inservice Training & Education			1,642	1,642		1,642		1,642		23
24	Travel and Seminar			2,184	2,184		2,184	(159)	2,025		24
25	Other Admin. Staff Transportation			9,948	9,948	(4,974)	4,974		4,974		25
26	Insurance-Prop.Liab.Malpractice			58,011	58,011		58,011	61,237	119,248		26
27	Other (specify):* See Att Sch VI	39,430		2,498	41,928		41,928	(41,928)			27
28	<b>TOTAL General Administration</b>	<b>277,879</b>	<b>38,348</b>	<b>933,404</b>	<b>1,249,631</b>	<b>(4,974)</b>	<b>1,244,657</b>	<b>(56,506)</b>	<b>1,188,151</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>2,670,640</b>	<b>1,049,044</b>	<b>1,814,299</b>	<b>5,533,983</b>		<b>5,533,983</b>	<b>(59,812)</b>	<b>5,474,171</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 Seminary Manor #0047233 Report Period Beginning: 10/01/07 Ending: 9/30/08

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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>D. Ownership</b>											
30	Depreciation			57,375	57,375		57,375	276,187	333,562			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			4,940	4,940		4,940	463,483	468,423			32
33	Real Estate Taxes							137,164	137,164			33
34	Rent-Facility & Grounds			802,778	802,778		802,778	(802,778)				34
35	Rent-Equipment & Vehicles			1,595	1,595		1,595		1,595			35
36	Other (specify):* <a href="#">See Att Sch V</a>							8,695	8,695			36
37	<b>TOTAL Ownership</b>			866,688	866,688		866,688	82,751	949,439			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			61,507	61,507		61,507		61,507			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			5,569	5,569		5,569		5,569			41
42	Provider Participation Fee			66,430	66,430		66,430		66,430			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			133,506	133,506		133,506		133,506			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,670,640	1,049,044	2,814,493	6,534,177		6,534,177	22,939	6,557,116			45

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

Facility Name & ID Number Seminary Manor

# 0047233

Report Period Beginning:

10/01/07

Ending:

9/30/08

**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		V-30		9
10	Interest and Other Investment Income	(334)	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	(211)	V-27		24
25	Fund Raising, Advertising and Promotional	(81,707)	V-20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Att Sch VII	(48,907)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (131,159)		\$	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)	145,065		34
35	Other- Attach Schedule See Att Sch III	9,033		35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 154,098		36
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ 22,939		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						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

Seminary Manor

ID# 0047233  
 Report Period Beginning: 10/01/07  
 Ending: 9/30/08

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	<b>Total</b>	0	49



STATE OF ILLINOIS

Facility Name & ID Number Seminary Manor

# 0047233

Report Period Beginning:

10/01/07 Ending:

Summary B

9/30/08

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	145,065	0	0	0	0	0	0	0	0	0	145,065	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>145,065</b>	<b>0</b>	<b>145,065</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> (sum of lines 29, 37 & 44)	<b>0</b>	<b>145,065</b>	<b>0</b>	<b>145,065</b>	<b>45</b>								

Facility Name & ID Number Seminary Manor

# 0047233

Report Period Beginning:

10/01/07

Ending:

9/30/08

**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
None	N/A	See Attached Schedule I		See Attached Schedule I		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 Facility rent	\$ 802,778	Galesburg North Seminary, LLC	N/A	\$ 947,843	\$ 145,065	1
2	V							2
3	V							3
4	V							4
5	V			See Att Schedule 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		\$ 802,778			\$ 947,843	\$ * 145,065	14

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

Facility Name & ID Number Seminary Manor # 0047233 Report Period Beginning: 10/01/07 Ending: 9/30/08

## VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	See Attached Schedule II & III								\$ 3,375	18-7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 3,375		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Seminary Manor

# 0047233

Report Period Beginning: 10/01/07

Ending: 9/30/08

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES  NO

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

Name of Related Organization Unlimited Development, Inc.  
 Street Address 285 S Farnham  
 City / State / Zip Code Galesburg, IL 61401  
 Phone Number ( 309) 343-1550  
 Fax Number ( 309) 343-2857

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2	See Att Schedule II & III							9,033	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				\$	\$		\$	9,033

**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	Cambridge Realty Capital						\$	\$		\$	1						
2	LTD. Of Illinois		X	facility purchase	\$47,507.82	7/1/2005	9,180,000	8,870,598	8/1/2040	5.2000	463,817	2					
3												3					
4												4					
5												5					
<b>Working Capital</b>																	
6	Miscellaneous		X									6					
7	Less Interest Income										(334)	7					
8												8					
9	<b>TOTAL Facility Related</b>				\$47,507.82		\$ 9,180,000	\$ 8,870,598			\$ 463,483	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>						\$ 9,180,000	\$ 8,870,598			\$ 463,483	15					

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 44,597 Line # 26

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

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



**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

**2007 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Seminary Manor COUNTY Knox

FACILITY IDPH LICENSE NUMBER 0047233

CONTACT PERSON REGARDING THIS REPORT Ron Wilson

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

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

Enter the tax index number and real estate tax assessed for 2007 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 2007.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>99-02-101-005</u>	<u>Hawthorne Centre Sub Ex</u>	\$ <u>                    </u>	\$ <u>                    </u>
2. <u>                    </u>	<u>E50 Ft Lot 1 Blk 1</u>	\$ <u>127,919.34</u>	\$ <u>127,919.34</u>
3. <u>99-02-101-009</u>	<u>Hawthorne Centre Resub No 5</u>	\$ <u>                    </u>	\$ <u>                    </u>
4. <u>                    </u>	<u>Pt Lt 6-Beg NW Cor S50'E413'</u>	\$ <u>                    </u>	\$ <u>                    </u>
5. <u>                    </u>	<u>N50.01'W412.84'To POB-AKA</u>	\$ <u>                    </u>	\$ <u>                    </u>
6. <u>                    </u>	<u>TR-6A</u>	\$ <u>1,666.38</u>	\$ <u>1,666.38</u>
7. <u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
8. <u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
9. <u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
10. <u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
<b>TOTALS</b>		\$ <u>129,585.72</u>	\$ <u>129,585.72</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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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

Facility Name & ID Number Seminary Manor

# 0047233 Report Period Beginning:

10/01/07 Ending:

9/30/08

**X. BUILDING AND GENERAL INFORMATION:**

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

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

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

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

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

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

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

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

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>4.33 Acres</u>	<u>2005</u>	<u>\$ 287,000</u>	1
2					2
3	<b>TOTALS</b>	<b>#VALUE!</b>		<b>\$ 287,000</b>	3

Facility Name & ID Number Seminary Manor

# 0047233

Report Period Beginning:

10/01/07

Ending:

9/30/08

**XI. OWNERSHIP COSTS (continued)**

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	121		2005		\$ 9,633,067	\$ 240,827	40	\$ 240,827		\$ 762,618	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9		Fire Door Closers		2005	3,059	204	15	204		578	9
10		Air conditioners		2006	9,942	994	10	994		2,485	10
11		Electric Sign-Double Face		2006	39,915	3,992	10	3,992		10,645	11
12		Concrete		2006	6,963	464	15	464		1,083	12
13		Asphalt Drive		2006	7,360	920	8	920		2,147	13
14		Door w/side Windows		2006	3,103	207	15	207		466	14
15		Dining Room Addition		2006	4,501	300	15	300		650	15
16		Door Alarm		2006	3,177	318	10	318		662	16
17		Phone Modem		2006	2,906	581	5	581		1,210	17
18		Air Conditioners		2007	4,921	492	10	492		820	18
19		Marble Vinyl floor tile		2007	2,904	290	10	290		556	19
20		Dining room cabinetry		2007	2,100	140	15	140		268	20
21		Concrete Sidewalk		2007	4,480	299	15	299		548	21
22		Euromarble vinyl tile		2007	4,482	448	10	448		822	22
23		Roof/roof deck repair		2007	62,606	6,261	10	6,261		10,435	23
24		Deck Repair/roof replacement		2007	12,474	1,247	10	1,247		2,287	24
25		Window treatments		2007	3,624	725	5	725		785	25
26		Roof replacement		2007	26,251	2,625	10	2,625		4,375	26
27		Roof		2008	10,625	531	10	531		531	27
28		Roof		2008	15,195	760	10	760		760	28
29		Roof		2008	15,580	649	10	649		649	29
30		Roof		2008	4,633	193	10	193		193	30
31		Fire Dampers		2008	6,438	107	10	107		107	31
32		Condensor		2008	3,548	79	15	79		79	32
33		Sidewalks		2008	2,887	48	15	48		48	33
34		Prime Walls/Paint		2008	4,560	76	5	76		76	34
35		Condensing units/Refrigeration Piping		2008	6,352	353	15	353		353	35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Seminary Manor

# 0047233

Report Period Beginning:

10/01/07

Ending:

9/30/08

**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	Air Conditioner	2008	\$ 3,408	\$ 568	5	\$ 568	\$	\$ 568	37
38	Hand Rail	2008	2,781	155	15	155		155	38
39	Double Door with Sidelights	2008	12,030	1,003	10	1,003		1,003	39
40	Roof Repairs	2008	25,054	1,253	10	1,253		1,253	40
41	Roof Repairs-Garage	2008	4,550	114	10	114		114	41
42	Sprinklers	2008	2,726	27	25	27		27	42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 9,958,202	\$ 267,250		\$ 267,250	\$	\$ 809,356	70

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

Facility Name & ID Number Seminary Manor # 0047233 Report Period Beginning: 10/01/07 Ending: 9/30/08

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	\$ 479,054	\$ 49,439	\$ 49,439	\$	3-15 yrs	\$ 145,548	71
72	Current Year Purchases	145,609	9,547	9,547		5-15 yrs	9,547	72
73	Fully Depreciated Assets							73
74	Indirect costs		965	965				74
75	TOTALS	\$ 624,663	\$ 59,951	\$ 59,951	\$		\$ 155,095	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Care	2008 Ford E450 Universal	2008	\$ 50,950	\$ 1,061	\$ 1,061	\$	4	\$ 1,061	76
77	Patient Care	2002 Ford F 250	2006	21,200	5,300	5,300		4	12,808	77
78										78
79										79
80	TOTALS			\$ 72,150	\$ 6,361	\$ 6,361	\$		\$ 13,869	80

E. Summary of Care-Related Assets

	1	Reference	2	Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)		\$ 10,942,015	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 333,562	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 333,562	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)		\$ 978,320	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	2006 Toyota Corolla-2006	\$ 14,900	\$ 3,725	\$ 8,692	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 14,900	\$ 3,725	\$ 8,692	91

G. Construction-in-Progress

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

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

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

**XII. RENTAL COSTS**

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

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

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

If NO, see instructions.  YES  NO

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

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

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

12.	<u>/2009</u>	\$ <u>N/A</u>
13.	<u>/2010</u>	\$ <u>N/A</u>
14.	<u>/2011</u>	\$ <u>N/A</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: \$ 1,595 Description: See Attached Schedule XIII

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

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

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

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

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

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

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

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
<b>TOTAL TRAINED</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 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	<b>TOTAL</b>			\$		\$	\$		\$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Seminary Manor# 0047233Report Period Beginning: 10/01/07

Ending:

9/30/08

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 9/30/08

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 8,330	\$ 27,109	1
2	Cash-Patient Deposits	9,952	9,952	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>5,132</u> )	2,009,947	2,009,947	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	66,625	114,663	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Att Sch VIII</u>	254,222	272,059	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 2,349,076	\$ 2,433,730	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost		287,000	14
15	Leasehold Improvements, at Historical Cost	298,882	9,958,202	15
16	Equipment, at Historical Cost	356,780	711,713	16
17	Accumulated Depreciation (book methods)	(107,622)	(987,012)	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 Sch VIII</u>	131,812	443,593	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 679,852	\$ 10,413,496	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 3,028,928	\$ 12,847,226	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 356,306	\$ 277,077	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	9,952	9,952	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	62,909	62,909	30
31	Accrued Taxes Payable (excluding real estate taxes)	9,879	9,879	31
32	Accrued Real Estate Taxes(Sch.IX-B)		97,191	32
33	Accrued Interest Payable	4,940	43,379	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Interdivision Payable</u>	1,515,247	2,915,854	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,959,233	\$ 3,416,241	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable		8,870,598	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44	<u>Security deposits</u>	61,030	61,030	44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 61,030	\$ 8,931,628	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 2,020,263	\$ 12,347,869	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 1,008,665	\$ 499,357	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 3,028,928	\$ 12,847,226	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 356,701	1
2	Restatements (describe):		2
3	<a href="#">See Att Schedule XI</a>	(29,418)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 327,283	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	681,382	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 681,382	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)	\$ 1,008,665	24 *

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

Facility Name & ID Number Seminary Manor# 0047233Report Period Beginning: 10/01/07Ending: 9/30/08**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	\$ 7,165,163	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 7,165,163	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	13,352	6
7	Oxygen	15,660	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 29,012	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	8,471	12
13	Barber and Beauty Care	6,966	13
14	Non-Patient Meals	1,481	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	25	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	160	20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 17,103	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	100	24
25	Interest and Other Investment Income***	334	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 434	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>Activity Fund Income</b>	3,306	28
28a	<b>See Att Schedule XII</b>	541	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 3,847	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 7,215,559	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,250,282	31
32	Health Care	3,034,070	32
33	General Administration	1,249,631	33
<b>B. Capital Expense</b>			
34	Ownership	866,688	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	67,076	35
36	Provider Participation Fee	66,430	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 6,534,177	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	681,382	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 681,382	43

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

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

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

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

Facility Name & ID Number Seminary Manor

# 0047233

Report Period Beginning: 10/01/07

Ending: 9/30/08

**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	1,993	2,143	\$ 64,281	\$ 30.00	1
2	Assistant Director of Nursing			0		2
3	Registered Nurses	5,651	6,076	138,228	22.75	3
4	Licensed Practical Nurses	27,234	29,284	450,685	15.39	4
5	CNAs & Orderlies	105,057	112,964	1,041,531	9.22	5
6	CNA Trainees					6
7	Licensed Therapist			0		7
8	Rehab/Therapy Aides			0		8
9	Activity Director			0		9
10	Activity Assistants	6,057	6,513	59,597	9.15	10
11	Social Service Workers	3,081	3,313	36,442	11.00	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	26,880	28,903	254,347	8.80	15
16	Dishwashers					16
17	Maintenance Workers	3,793	4,078	63,743	15.63	17
18	Housekeepers	12,099	13,009	113,832	8.75	18
19	Laundry	5,754	6,187	48,757	7.88	19
20	Administrator	1,934	2,080	141,408	67.98	20
21	Assistant Administrator	1,901	2,044	30,155	14.75	21
22	Other Administrative	1,934	2,080	39,430	18.96	22
23	Office Manager					23
24	Clerical	6,033	6,487	66,886	10.31	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,152	2,314	20,247	8.75	31
32	Other Health Care(specify)	5,424	5,832	101,071	17.33	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	216,977	233,307	\$ 2,670,640 *	\$ 11.45	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	***	\$ 8,865	1-3	35
36	Medical Director	***	32,226	9-3	36
37	Medical Records Consultant	***	0	10-3	37
38	Nurse Consultant	***	0	10-3	38
39	Pharmacist Consultant	***	1,500	10-3	39
40	Physical Therapy Consultant	***	318,268	10a-3	40
41	Occupational Therapy Consultant	***	191,163	10a-3	41
42	Respiratory Therapy Consultant	***	0	10a-3	42
43	Speech Therapy Consultant	***	80,851	10a-3	43
44	Activity Consultant	***		11-3	44
45	Social Service Consultant	***		12-3	45
46	Other(specify) <u>Dental Consultants</u>	***	0	10-3	46
47					47
48	<u>*** Monthly fee</u>				48
49	TOTAL (lines 35 - 48)		\$ 632,873		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





**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. See Page 21 section F
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes - IHCA dues If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 25,871 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 66,430  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ None Has any meal income been offset against related costs? Yes Indicate the amount. \$ 0
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? None
- d. Have vehicle usage logs been maintained? Yes
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: McGladrey & Pullen, LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Audit not yet completed
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.