



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

# 0034066 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

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	255	Intermediate (ICF)	255	93,075	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	255	TOTALS	255	93,075	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total	
		3 Medicaid Recipient	4 Private Pay	Other	Total		
8	SNF					8	
9	SNF/PED					9	
10	ICF	77,936	0		77,936	10	
11	ICF/DD					11	
12	SC					12	
13	DD 16 OR LESS					13	
14	TOTALS	77,936			77,936	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.73%

D. How many bed-hold days during this year were paid by the Department? 1,656 (Do not include bed-hold days in Section B.)

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

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

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

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

I. On what date did you start providing long term care at this location?  
Date started 04/01/80

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

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

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 6/30/2010 Fiscal Year: 6/30/2010

\* 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: 07/01/2009 Ending: 06/30/2010

**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	457,885	31,282	4,572	493,739		493,739		493,739		1
2	Food Purchase		446,518		446,518	(11,556)	434,962		434,962		2
3	Housekeeping	347,492	61,901		409,393		409,393		409,393		3
4	Laundry	206,068	38,065		244,133		244,133		244,133		4
5	Heat and Other Utilities			292,591	292,591		292,591		292,591		5
6	Maintenance	165,330	70,315	107,280	342,925		342,925		342,925		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	1,176,775	648,081	404,443	2,229,299	(11,556)	2,217,743		2,217,743		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			20,400	20,400		20,400		20,400		9
10	Nursing and Medical Records	4,148,818	203,771	22,528	4,375,117		4,375,117		4,375,117		10
10a	Therapy			9,464	9,464		9,464		9,464		10a
11	Activities	89,771	15,201	53,171	158,143		158,143	(31,263)	126,880		11
12	Social Services	102,529		550	103,079		103,079		103,079		12
13	CNA Training										13
14	Program Transportation					13,097	13,097		13,097		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	4,341,118	218,972	106,113	4,666,203	13,097	4,679,300	(31,263)	4,648,037		16
	<b>C. General Administration</b>										
17	Administrative	91,661			91,661		91,661		91,661		17
18	Directors Fees			11,300	11,300		11,300		11,300		18
19	Professional Services			507,097	507,097		507,097	(3,682)	503,415		19
20	Dues, Fees, Subscriptions & Promotions			20,535	20,535		20,535	(383)	20,152		20
21	Clerical & General Office Expenses	158,703	39,392	14,373	212,468		212,468		212,468		21
22	Employee Benefits & Payroll Taxes			1,383,266	1,383,266	11,556	1,394,822		1,394,822		22
23	Inservice Training & Education										23
24	Travel and Seminar			116	116		116		116		24
25	Other Admin. Staff Transportation			26,193	26,193	(13,097)	13,096		13,096		25
26	Insurance-Prop.Liab.Malpractice			70,479	70,479		70,479	10,437	80,916		26
27	Other (specify):* <a href="#">See Att Sch VII</a>			662	662		662	(662)			27
28	<b>TOTAL General Administration</b>	250,364	39,392	2,034,021	2,323,777	(1,541)	2,322,236	5,710	2,327,946		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	5,768,257	906,445	2,544,577	9,219,279		9,219,279	(25,553)	9,193,726		29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

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

#0034066

Report Period Beginning:

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Ending:

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## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			134,868	134,868		134,868	213,912	348,780			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							321,544	321,544			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			576,000	576,000		576,000	(576,000)				34
35	Rent-Equipment & Vehicles			330	330		330		330			35
36	Other (specify):* See Att Sch III							38,658	38,658			36
37	<b>TOTAL Ownership</b>			711,198	711,198		711,198	(1,886)	709,312			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			552,640	552,640		552,640		552,640			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			552,640	552,640		552,640		552,640			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	5,768,257	906,445	3,808,415	10,483,117		10,483,117	(27,439)	10,455,678			45

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

**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	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
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	(261)	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	(662)	V-27		24
25	Fund Raising, Advertising and Promotional	(383)	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 IV	(34,945)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (36,251)		\$	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	
		<b>Amount</b>	<b>Reference</b>	
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)	8,812		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 8,812		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (27,439)		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	
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>	
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

<b>BHF USE ONLY</b>							
48		49		50		51	52

St Mary's Square Living Center

ID# 0034066

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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 St Mary's Square Living Center# 0034066

Report Period Beginning:

07/01/2009 Ending:

Summary B

06/30/2010

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
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	8,812	0	0	0	0	0	0	0	0	0	8,812	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>8,812</b>	<b>0</b>	<b>8,812</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>
	<b>GRAND TOTAL COST</b>													
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>0</b>	<b>8,812</b>	<b>0</b>	<b>8,812</b>	<b>45</b>								

**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
<u>Community Residential Centers, Inc.</u>				<u>CRC Cherry Street Facility, LLC</u>		
<u>(Non-profit Organization)</u>					<u>Galesburg</u>	<u>Lessor</u>
				<u>LTC Support Services, LLC</u>		
					<u>Galesburg</u>	<u>Support Services</u>

**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	<u>34 Rent</u>	<u>\$ 576,000</u>	<u>CRC Cherry Street Facility, LLC</u>	<u>N/A</u>	<u>\$ 584,812</u>	<u>\$ 8,812</u>	<u>1</u>
2	V							<u>2</u>
3	V							<u>3</u>
4	V			<u>LTC Support Services, LLC</u>				<u>4</u>
5	V			<u>See Accountant's Report</u>				<u>5</u>
6	V							<u>6</u>
7	V							<u>7</u>
8	V							<u>8</u>
9	V							<u>9</u>
10	V							<u>10</u>
11	V							<u>11</u>
12	V							<u>12</u>
13	V							<u>13</u>
14	<b>Total</b>		<b>\$ 576,000</b>			<b>\$ 584,812</b>	<b>\$ *</b>	<b>8,812 14</b>

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

Facility Name &amp; ID Number

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# 0034066

Report Period Beginning:

07/01/2009

Ending:

06/30/2010

## 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	3,000	18-3	2
3	Gary Bruington	Director	Director	None	N/A	N/A	N/A	Board mtgs	3,000	18-3	3
4	David Beversdorf	Director	Director	None	N/A	N/A	N/A	Board mtgs	3,000	18-3	4
5											5
6								Training and meeting expenses	300		6
7								Less: Non-allowable out-of-state travel	0		7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 11,300		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

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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 \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

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

Facility Name & ID Number

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# 0034066

Report Period Beginning:

07/01/2009

Ending:

06/30/2010

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

1	2	3	4	5	6		8	9	10									
					Name of Lender	Related**				Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
						YES							NO	Original				Balance
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1	GMAC Commercial					\$		\$		\$	1							
2	Mortgage Corp	X	Facility Purchase	\$39,717.00	09/01/2003	6,164,400	5,128,523	10/1/2028	6.0000	321,805	2							
3											3							
4											4							
5											5							
<b>Working Capital</b>																		
6											6							
7	Interest Income	X	Page 5, line 10							(261)	7							
8	Misc. Operating	X									8							
9	<b>TOTAL Facility Related</b>			\$39,717.00		\$ 6,164,400	\$ 5,128,523			\$ 321,544	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	\$ 5,128,523			\$ 321,544	15							

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 26,812 Line # V-26

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

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

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

**B. Real Estate Taxes**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>			
1. Real Estate Tax accrual used on 2009 report.		\$	(46,877)		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.)		\$			2
3. Under or (over) accrual (line 2 minus line 1).		\$	46,877		3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		\$			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 \$ 46,877 For 2006 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	(46,877)		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$			7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2005	186,892	8	<b>FOR BHF USE ONLY</b>	
	2006	187,507	9		
	2007	N/A	10	13	FROM R. E. TAX STATEMENT FOR 2009 \$ 13
	2008	N/A	11	14	PLUS APPEAL COST FROM LINE 5 \$ 14
	2009	N/A	12	15	LESS REFUND FROM LINE 6 \$ 15
<b>Real estate taxes are not assessed due to the facility receiving an exemption in 2007 eff. for the calendar yr 2006. Therefore, no accrual for the real estate tax is required. The prior year receivable amount due from the county for the 2006 RE tax refund was received in the current year.</b>				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.**



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

# 0034066

Report Period Beginning:

07/01/2009 Ending:

06/30/2010

**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).

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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:**

	1	2	3	4	
A. Land.	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:

07/01/2009

Ending:

06/30/2010

**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		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	255	2003		\$ 6,220,000	\$ 207,333	30	\$ 207,333	\$	\$ 1,399,505	4
5		2003		131,518	6,576	20	6,576		43,292	5
6										6
7										7
8										8
<b>Improvement Type**</b>										
9	Garage Addition, sidewalk, furnace, elevator		1988	46,740		15-20 yrs			46,740	9
10	Sprinkler, roof repair		1989	29,422	526	20-25 yrs	526		29,190	10
11	Water chiller repair, boiler repair		1990	11,633	270	15-20 yrs	270		11,633	11
12	Roof repair, roofing		1991	49,477	2,474	20	2,474		47,906	12
13	Heater, furnace		1992	2,505		15			2,505	13
14	Windows, sidewalk		1993	7,150		15			7,150	14
15	Paving, plumbing, boiler equipment, roofing		1994	30,695	485	10-20 yrs	485		29,029	15
16	A/C chiller, tuckpoint, roofing, transformer, elevator equip		1995	102,052	4,771	15-25 yrs	4,771		70,033	16
17	Alarm electric work, water heater, door closers, A.C units, stucco work		1996	62,518	2,553	10-25 yrs	2,553		50,828	17
18	A/C units, fire alarm system, paving		1997	62,969	518	8-15 yrs	518		62,145	18
19	Fire alarm, paving, condensate ret. System		1998	16,340	227	8-15 yrs	227		15,583	19
20	Coils & stats, fire alarm, commercial door		1999	62,346	1,299	10-15 yrs	1,299		61,188	20
21	Kitchen upgrade, air conditioner rep, countertop, hall handle rep, HVAC		2000	30,547	2,332	10-15 yrs	2,332		23,390	21
22	Patio, Elevator renovation		2002	77,220	3,861	20	3,861		29,865	22
23	Air handler, Concrete construction, Vinyl flooring, patio constr.		2003	46,624	2,655	10-20 yrs	2,655		18,725	23
24	2004 Additions		2004	360,167	23,321	5-25 yrs	23,321		145,621	24
25	2005 Additions		2005	39,174	3,865	10	3,865		19,619	25
26	Sprinkler system		2006	25,839	1,723	15	1,723		7,034	26
27	Elevator		2008	32,584	1,629	20	1,629		3,394	27
28	Air conditioner		2008	12,818	1,282	10	1,282		2,350	28
29	Door closers		2008	2,970	297	10	297		569	29
30	Shower room repairs (tile)		2008	2,715	272	10	272		453	30
31	Reclining air massage tub		2008	13,026	1,303	10	1,303		2,280	31
32	Water heater		2008	3,100	310	10	310		517	32
33	New valve on elevator		2009	12,644	632	20	632		895	33
34	Generator back-up freezer/refrigerator		2009	5,610	1,122	5	1,122		1,590	34
35	Electrical work - elevator		2009	4,600	230	20	230		307	35
36										36

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building 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	Elevator	2009	\$ 77,440	\$ 3,872	20	\$ 3,872	\$	\$ 4,840	37
38	Circuit and well pump installation	2009	5,387	269	20	269		314	38
39	3rd Floor shower room remodel	2009	17,985	899	20	899		1,049	39
40	Truck pointing & foundation repaid	2009	18,800	940	20	940		1,018	40
41	Fire alarm	2009	3,293	329	10	329		356	41
42	Door closures - part of alarm system	2009	4,134	230	15	230		230	42
43	Rewire Elevator Controllers	2010	5,871	147	20	147		147	43
44	Water Heater	2010	5,698	142	10	142		142	44
45	Boiler Repairs	2010	4,394	37	10	37		37	45
46	Bathroom remodels - walls/floors/showers/toilets/cabinets/sink/cou	2010	137,256	953	12	953		953	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)		\$ 7,785,261	\$ 279,684		\$ 279,684	\$	\$ 2,142,422	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:

07/01/2009

Ending:

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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	\$ 548,190	\$ 40,915	\$ 40,915	\$	3-20 yrs	\$ 364,001	71
72	Current Year Purchases	7,953	531	531		10-12 yrs	531	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 556,143	\$ 41,446	\$ 41,446	\$		\$ 364,532	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	\$ 240,125	\$ 27,650	\$ 27,650	\$	4 yrs	\$ 185,438	76
77										77
78										78
79										79
80	TOTALS			\$ 240,125	\$ 27,650	\$ 27,650	\$		\$ 185,438	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)	\$ 8,765,529	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 348,780	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 348,780	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)	\$ 2,692,392	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	\$ 90,916	92
93			93
94			94
95		\$ 90,916	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 - See Attached Schedule II

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

If NO, see instructions.  YES  NO

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

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease \_\_\_\_\_.

N/A

N/A

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

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

15. Is Movable equipment rental included in building rental?

YES  NO

16. Rental Amount for movable equipment: \$ N/A Description: N/A - facility owned

(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

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. /2011 \$ \_\_\_\_\_

13. /2012 \$ \_\_\_\_\_

14. /2013 \$ \_\_\_\_\_

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

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

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <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>
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**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)		66,242		66,242
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 66,242	\$	\$ 66,242
10	SUM OF line 9, col. 1 and 2 (e)	\$	66,242		

**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	36
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	<b>36</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	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		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 St Mary's Square Living Center# 0034066Report Period Beginning: 07/01/2009Ending: 06/30/2010

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/2010

(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	\$ 1,292,860	\$ 1,367,213	1
2	Cash-Patient Deposits	13,201	13,201	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>25,000</u> )	2,751,109	2,751,109	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	62,157	80,019	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Other Receivable</u>	257,850	257,850	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 4,377,177	\$ 4,469,392	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments	10,000	10,000	12
13	Land		184,000	13
14	Buildings, at Historical Cost		6,351,518	14
15	Leasehold Improvements, at Historical Cost	1,433,743	1,433,743	15
16	Equipment, at Historical Cost	796,268	796,268	16
17	Accumulated Depreciation (book methods)	(1,249,592)	(2,692,392)	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)	90,916	90,916	22
23	Other(specify): <u>See Att Sch V</u>		917,218	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,081,335	\$ 7,091,271	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 5,458,512	\$ 11,560,663	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 216,433	\$ 216,731	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	13,201	13,201	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	632,548	632,548	30
31	Accrued Taxes Payable (excluding real estate taxes)	25,730	25,730	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable		26,460	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>Accr Health Insurance Assessment</u>	62,831	62,831	36
37	<u>Curr Maturities of Mortgage</u>		163,533	37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 950,743	\$ 1,141,034	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable	1,650,000	1,650,000	39
40	Mortgage Payable		5,128,523	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 (sum of lines 39 thru 44)</b>	\$ 1,650,000	\$ 6,778,523	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 2,600,743	\$ 7,919,557	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 2,857,769	\$ 3,641,106	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 5,458,512	\$ 11,560,663	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>2,969,014</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>To adjust payroll</b>	<b>(4,850)</b>	<b>3</b>
<b>4</b>	<b>To adjust training receivable</b>	<b>31,270</b>	<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>2,995,434</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(137,665)</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(137,665)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>2,857,769</b>	<b>24</b> *

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

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

# 0034066

Report Period Beginning: 07/01/2009

Ending: 06/30/2010

**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	\$ 9,945,207	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 9,945,207	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	66,242	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>	\$ 66,242	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	22,771	24
25	Interest and Other Investment Income***	261	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 23,032	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See Att Sch VI</u>	310,971	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 310,971	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 10,345,452	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	2,229,299	31
32	Health Care	4,666,203	32
33	General Administration	2,323,777	33
<b>B. Capital Expense</b>			
34	Ownership	711,198	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers		35
36	Provider Participation Fee	552,640	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 10,483,117	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(137,665)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (137,665)	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: 07/01/2009

Ending: 06/30/2010

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	1,960	2,160	\$ 60,470	\$ 28.00	1
2	Assistant Director of Nursing	1,960	2,080	48,946	23.53	2
3	Registered Nurses	8,410	9,043	180,859	20.00	3
4	Licensed Practical Nurses	41,585	44,715	724,831	16.21	4
5	CNAs & Orderlies	230,210	250,288	2,472,256	9.88	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	6,373	6,853	89,771	13.10	9
10	Activity Assistants					10
11	Social Service Workers	7,733	8,315	102,529	12.33	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	40,517	43,567	457,885	10.51	15
16	Dishwashers					16
17	Maintenance Workers	9,574	10,295	165,330	16.06	17
18	Housekeepers	31,934	34,337	347,492	10.12	18
19	Laundry	20,475	22,016	206,068	9.36	19
20	Administrator	1,867	2,007	91,661	45.67	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	13,704	14,736	158,703	10.77	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	41,673	44,810	633,161	14.13	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,677	2,878	28,295	9.83	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	460,652	498,100	\$ 5,768,257 *	\$ 11.58	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	***	\$ 4,572	1-3	35
36	Medical Director	***	20,400	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant	***	0	10-3	38
39	Pharmacist Consultant	***	0	10-3	39
40	Physical Therapy Consultant	***	3,508	10a-3	40
41	Occupational Therapy Consultant	***	2,918	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	***	3,038	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant	***	550	12-3	45
46	Other(specify) <u>Dental Consultant</u>	***	7,530	10-3	46
47	<u>Psychological Consultant</u>	***	14,998	10-3	47
48	<u>***Monthly Fee</u>				48
49	TOTAL (lines 35 - 48)		\$ 57,514		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

**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	\$ 91,661	Workers' Compensation Insurance	\$ 297,691	IDPH License Fee	\$				
				Unemployment Compensation Insurance	18,930	Advertising: Employee Recruitment	10,591				
				FICA Taxes	428,840	Health Care Worker Background Check					
				Employee Health Insurance	579,071	(Indicate # of checks performed <u>348</u> )	3,487				
				Employee Meals	11,556	Patient Background Checks	17				
				Illinois Municipal Retirement Fund (IMRF)*		Subscriptions	5,685				
				401(k)	44,876	Advertising - Promotional	383				
				Other Employee Benefits	13,858	Other Licenses and Fees	219				
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 91,661	TOTAL (agree to Schedule V, line 22, col.8)			\$ 1,394,822	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 20,152	
(List each licensed administrator separately.)								Less: Public Relations Expense		( )	
B. Administrative - Other								Non-allowable advertising		(383)	
Description			Amount					Yellow page advertising		( )	
			\$								
TOTAL (agree to Schedule V, line 17, col. 3)			\$	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**				
(Attach a copy of any management service agreement)				Description			Line #	Amount	Description	Amount	
C. Professional Services									Out-of-State Travel	\$	
Vendor/Payee	Type	Amount									
RFMS, Inc.	Administrative Services	\$ 279,510							In-State Travel		
McGladrey & Pullen, LLP	Accounting Services	117,680							Staff use of personal vehicle on facility		
RSM McGladrey, Inc.	Accounting Services	9,160							business and means (under \$250 per		
LTC Support Services, LLC	Support Services	81,000							travel voucher)	116	
Polsinelli Shughart, PC	Legal Services	15,348							Seminar Expense		
Crain, Miller & Wernsman, PC	Legal Services	4,399							Less: Non-allowable travel	0	
									Entertainment Expense	( )	
									(agree to Sch. V,		
TOTAL (agree to Schedule V, line 19, column 3)			\$ 507,097	TOTAL			\$	TOTAL		line 24, col. 8)	\$ 116
(If total legal fees exceed \$5,000, attach copy of invoices.)											

\* Attach copy of IMRF notifications

\*\*See instructions.



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

# 0034066

Report Period Beginning: 07/01/2009 Ending: 06/30/2010

**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? No  
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (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? 11 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 71,556 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. NA
- (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. \$ 552,640  
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. \$ 11,556 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (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? Yes  
**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
- (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? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.