FOR BHF USE

LL1

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

2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

I. IDPH License ID Number: 0047233

Facility Name: Seminary Manor

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

County: Knox

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

HFS ID Number:

Date of Initial License for Current Owners: 7/28/2005

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code 501 (c) (3)			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 10/1/09 to 9/30/10 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name) Ben Perkins
(Title) Director of Operations

Paid Preparer
(Signed) See Attached Independent Accountant's Report (Date)
(Print Name and Title) McGladrey & Pullen, LLP, 117 E. Main St., Suite 210
(Firm Name & Address) P.O. Box 1070, Galesburg, IL 61401
(Telephone) (309) 342-1175 Fax # (309) 342-7816

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Seminary Manor # 0047233 Report Period Beginning: 10/1/09 Ending: 9/30/10

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	121	Skilled (SNF)	121	44,165	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	121	TOTALS	121	44,165	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	11,373	13,849	12,916	38,138	8
9	SNF/PED					9
10	ICF		0			10
11	ICF/DD					11
12	SC		0			12
13	DD 16 OR LESS					13
14	TOTALS	11,373	13,849	12,916	38,138	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.35%

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 [X]

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

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 [X] Date 07/28/05 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 121 and days of care provided 8,971

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 09/30/10 Fiscal Year: 09/30/10

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Seminary Manor # 0047233 Report Period Beginning: 10/1/09 Ending: 9/30/10

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	317,981	39,302	9,225	366,508		366,508		366,508			1
2	Food Purchase		402,149		402,149		402,149		402,149			2
3	Housekeeping	120,140	45,596	50	165,786		165,786		165,786			3
4	Laundry	51,808	18,943		70,751		70,751		70,751			4
5	Heat and Other Utilities			154,302	154,302		154,302		154,302			5
6	Maintenance	69,620	46,873	63,033	179,526		179,526		179,526			6
7	Other (specify):*											7
8	TOTAL General Services	559,549	552,863	226,610	1,339,022		1,339,022		1,339,022			8
	B. Health Care and Programs											
9	Medical Director			36,750	36,750		36,750		36,750			9
10	Nursing and Medical Records	1,979,066	634,879	8,894	2,622,839		2,622,839		2,622,839			10
10a	Therapy	941		686,109	687,050		687,050		687,050			10a
11	Activities	82,847	4,464		87,311		87,311		87,311			11
12	Social Services	19,015			19,015		19,015		19,015			12
13	CNA Training											13
14	Program Transportation			474	474	3,988	4,462		4,462			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,081,869	639,343	732,227	3,453,439	3,988	3,457,427		3,457,427			16
	C. General Administration											
17	Administrative	164,823			164,823		164,823		164,823			17
18	Directors Fees							3,350	3,350			18
19	Professional Services			338,248	338,248		338,248	1,615	339,863			19
20	Dues, Fees, Subscriptions & Promotions			73,807	73,807		73,807	(56,090)	17,717			20
21	Clerical & General Office Expenses	87,279	41,498	41,046	169,823		169,823	(4,839)	164,984			21
22	Employee Benefits & Payroll Taxes			482,847	482,847		482,847		482,847			22
23	Inservice Training & Education			1,521	1,521		1,521		1,521			23
24	Travel and Seminar			400	400		400		400			24
25	Other Admin. Staff Transportation			7,975	7,975	(3,988)	3,987		3,987			25
26	Insurance-Prop.Liab.Malpractice			47,971	47,971		47,971	54,257	102,228			26
27	Other (specify):* See Att Sch V	76,133		114,584	190,717		190,717	(190,717)				27
28	TOTAL General Administration	328,235	41,498	1,108,399	1,478,132	(3,988)	1,474,144	(192,424)	1,281,720			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,969,653	1,233,704	2,067,236	6,270,593		6,270,593	(192,424)	6,078,169			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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: 10/1/09 Ending: 9/30/10

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			107,738	107,738		107,738	273,371	381,109			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							450,091	450,091			32
33	Real Estate Taxes							142,800	142,800			33
34	Rent-Facility & Grounds			818,300	818,300		818,300	(818,300)				34
35	Rent-Equipment & Vehicles			10,676	10,676		10,676		10,676			35
36	Other (specify):* See Att Sch IV							8,478	8,478			36
37	TOTAL Ownership			936,714	936,714		936,714	56,440	993,154			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			79,365	79,365		79,365		79,365			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			6,113	6,113		6,113		6,113			41
42	Provider Participation Fee			66,248	66,248		66,248		66,248			42
43	Other (specify):* Outpatient Care			650	650		650		650			43
44	TOTAL Special Cost Centers			152,376	152,376		152,376		152,376			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,969,653	1,233,704	3,156,326	7,359,683		7,359,683	(135,984)	7,223,699			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Seminary Manor # 0047233 Report Period Beginning: 10/1/09 Ending: 9/30/10

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 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	(2,104)	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	(5,000)	V-21		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	(112,474)	V-27		24
25	Fund Raising, Advertising and Promotional	(56,092)	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 VI	(83,818)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (259,488)		$	30

BHF USE ONLY									
48		49		50		51		52	

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 Amount	2 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)	118,376		34
35	Other- Attach Schedule **See Att Sch III**	5,128		35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 123,504		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (135,984)		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 Yes	2 No	3 Amount	4 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	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Seminary Manor

ID# 0047233

Report Period Beginning: 10/1/09

Ending: 9/30/10

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Seminary Manor # 0047233 **Report Period Beginning:** 10/1/09 **Ending:** 9/30/10

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

	Operating Expenses	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)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	0	0	0	0	0	0	0	0	0	0	0	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	0	0	0	0	0	0	0	0	0	0	0	0	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Seminary Manor # 0047233 **Report Period Beginning:** 10/1/09 **Ending:** 9/30/10

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)	
	D. Ownership													
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	118,376	0	0	0	0	0	0	0	0	0	118,376	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	118,376	0	0	0	0	0	0	0	0	0	118,376	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	0	118,376	0	0	0	0	0	0	0	0	0	118,376	45

Facility Name & ID Number Seminary Manor # 0047233 Report Period Beginning: 10/1/09 Ending: 9/30/10

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Facility Rent	$ 818,300	Galesburg North Seminary, LLC	N/A	$ 936,676	$ 118,376	1
2	V				See Att Schedule IV and Independent Accountant's Report				2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 818,300			$ 936,676	$ * 118,376	14

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

Facility Name & ID Number Seminary Manor # 0047233 Report Period Beginning: 10/1/09 Ending: 9/30/10

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	See Attached Schedule II & III								$ 3,350	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	$ 3,350		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: 10/1/09 Ending: 9/30/10

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 [X] 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2		See Att Sch II & III							5,128	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					$	$		$ 5,128	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Seminary Manor # 0047233 Report Period Beginning: 10/1/09 Ending: 9/30/10

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	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Cambridge Realty Capital						$	$			$	1
2	LTD. of Illinois		X	Facility purchase	$47,507.82	7/1/2005	9,180,000	8,641,754	8/1/2040	5.2000	452,195	2
3												3
4												4
5												5
	Working Capital											
6	Miscellaneous		X									6
7	Less Interest Income										(2,104)	7
8												8
9	TOTAL Facility Related				$47,507.82		$ 9,180,000	$ 8,641,754			$ 450,091	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 9,180,000	$ 8,641,754			$ 450,091	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** 43,479 **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.)**

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Seminary Manor # 0047233 **Report Period Beginning:** 10/1/09 **Ending:** 9/30/10

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 101,797	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.)		$ 141,411	2
3. Under or (over) accrual (line 2 minus line 1).		$ 39,614	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 103,186	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 142,800	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2005	117,645	8
	2006	118,032	9
	2007	129,586	10
	2008	135,794	11
	2009	141,411	12

This facility was purchased from an unrelated for-profit entity during 2005. A tax exemption has not yet been obtained.
Amount accrued includes estimated taxes for 9 months based on fiscal year end. Estimate is based on prior year tax bill.
Taxes paid are for the entire 2009 bill.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2009	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

2009 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 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	99-02-101-045	HAWTHORNE CENTRE SUB	$ 141,411.30	$ 141,411.30
2.		LOT 1 (EX E50 FT) BLK 1 &	$	$
3.		HAWTHORNE CENTRE RESUB	$	$
4.		NO - 5 PT LOT 6 - BEG NW	$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 141,411.30	$ 141,411.30

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 and 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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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: 10/1/09 Ending: 9/30/10

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 [X] (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? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

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

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

None

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	4.33 Acres	2005	$ 287,000	1
2					2
3	TOTALS	#VALUE!		$ 287,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Seminary Manor # 0047233 Report Period Beginning: 10/1/09 Ending: 9/30/10

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	120		2005		$ 9,633,067	$ 240,826	40	$ 240,826	$	$ 1,244,271	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Fire Door Closers			2005	3,059	204	15	204		986	9
10	A/C, Sign, Concrete, Asphalt, Door, Dining rm addn, Alarm, Modem			2006	77,867	7,775	5-15 yrs	7,775		34,899	10
11	Air Conditioner			2007	4,921	492	10	492		1,804	11
12	Marble Vinyl Floor Tile			2007	2,904	291	10	291		1,137	12
13	Dining room cabinerty			2007	2,100	140	15	140		548	13
14	Concrete sidewalk			2007	4,480	298	15	298		1,145	14
15	Euromarble vinyl tile			2007	4,482	448	10	448		1,718	15
16	Roof/roof deck repair			2007	62,606	6,260	10	6,260		22,956	16
17	Deck repair/roof replacement			2007	12,474	1,248	10	1,248		4,782	17
18	Window treatments			2007	3,624	725	5	725		2,235	18
19	Roof replacement			2007	26,251	2,626	10	2,626		9,626	19
20	Roof			2008	10,625	1,062	10	1,062		2,656	20
21	Roof			2008	15,195	1,519	10	1,519		3,799	21
22	Roof			2008	15,580	1,558	10	1,558		3,765	22
23	Roof			2008	4,633	464	10	464		1,120	23
24	Fire Dampers			2008	6,438	644	10	644		1,395	24
25	Condensor			2008	3,548	236	15	236		552	25
26	Sidewalks			2008	2,887	193	15	193		433	26
27	Prime Walls/Paint			2008	4,560	912	5	912		1,900	27
28	Condensing units/Refrigeration Piping			2008	6,352	424	15	424		1,200	28
29	Air Conditioner			2008	3,408	681	5	681		1,931	29
30	Hand rail			2008	2,781	185	15	185		525	30
31	Double door with Sidelights			2008	12,030	1,203	10	1,203		3,409	31
32	Roof Repairs			2008	25,054	2,506	10	2,506		6,264	32
33	Roof Repairs - Garage			2008	4,550	455	10	455		1,024	33
34	Sprinklers			2008	2,726	109	25	109		245	34
35	Lighting pole			2009	6,677	667	10	667		1,335	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: 10/1/09 Ending: 9/30/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Replace wall/ceiling sheetrock, tile, paint	2009	$ 39,005	$ 3,250	12	$ 3,250	$	$ 5,688	37
38	Roof replacement	2009	9,574	957	10	957		1,835	38
39	Rubber flooring	2009	14,397	1,439	10	1,439		2,759	39
40	Light posts concrete	2009	3,690	246	15	246		492	40
41	Parking lot light poles	2009	6,505	433	15	433		867	41
42	Parking lot (asphalt)	2009	40,752	5,094	8	5,094		10,188	42
43	Tile	2009	4,267	213	20	213		320	43
44	Waterheater	2009	7,074	707	10	707		1,002	44
45	Shower room	2009	30,990	2,066	15	2,066		3,099	45
46	Seminary Manor PT Addition	2009	152,233	6,090	25	6,090		11,164	46
47	Seminary Manor Garden Court Addition	2009	131,812	5,272	25	5,272		9,666	47
48	Concrete Parking Lot & Sidewalk	2009	12,869	858	15	858		1,144	48
49	Water Heater	2010	3,750	31	10	31		31	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)		$ 10,421,797	$ 300,807		$ 300,807	$	$ 1,405,915	70

SEE ACCOUNTANTS' COMPILATION REPORT

**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: 10/1/09 Ending: 9/30/10

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	$ 674,666	$ 66,382	$ 66,382	$	3-15 yrs	$ 286,164	71
72	Current Year Purchases	9,922	1,184	1,184		5-7 yrs	1,184	72
73	Fully Depreciated Assets							73
74	Indirect Costs							74
75	TOTALS	$ 684,588	$ 67,566	$ 67,566	$		$ 287,348	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	$ 12,736	$ 12,736	$	4 yrs	$ 26,535	76
77										77
78										78
79										79
80	TOTALS			$ 50,950	$ 12,736	$ 12,736	$		$ 26,535	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)	$ 11,444,335	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 381,109	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 381,109	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,719,798	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	2002 Ford F250 - 2006	$ 21,200	$ 3,092	$ 21,200	86
87	2006 Toyota Corolla - 2006	14,900	2,483	14,900	87
88					88
89					89
90					90
91	TOTALS	$ 36,100	$ 5,575	$ 36,100	91

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Seminary Manor # 0047233 Report Period Beginning: 10/1/09 Ending: 9/30/10

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. [X] 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:				$ See Attached			3
4	Additions				Schedule IV			4
5					Related Party			5
6					Lease			6
7	TOTAL				$			7

**

8. List separately any amortization of lease expense included on page 4, line 34. N/A
   This amount was calculated by dividing the total amount to be amortized N/A
   by the length of the lease N/A .

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

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	$ N/A
13.	/2012	$ N/A
14.	/2013	$ 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: $ 10,676 Description: See Attached Schedule XII
    (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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Seminary Manor # 0047233 Report Period Beginning: 10/1/09 Ending: 9/30/10

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Seminary Manor # 0047233 Report Period Beginning: 10/1/09 Ending: 9/30/10

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

		1	2	3	4	5	6	7	8	
	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 prescrpts							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	TOTAL			$		$	$		$	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Seminary Manor # 0047233 Report Period Beginning: 10/1/09 Ending: 9/30/10

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 9/30/10 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 12,877	$ 39,692	1
2	Cash-Patient Deposits	15,711	15,711	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,131,118	1,131,118	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	112,145	147,874	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Att Sch VII	298,967	343,013	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,570,818	$ 1,677,408	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		287,000	13
14	Buildings, at Historical Cost		9,659,320	14
15	Leasehold Improvements, at Historical Cost	762,477	762,477	15
16	Equipment, at Historical Cost	416,705	771,638	16
17	Accumulated Depreciation (book methods)	(318,619)	(1,755,898)	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): See Att Sch VII		324,801	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 860,563	$ 10,049,338	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,431,381	$ 11,726,746	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 140,475	$ 140,475	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	15,711	15,711	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	67,962	67,962	30
31	Accrued Taxes Payable (excluding real estate taxes)	12,907	12,907	31
32	Accrued Real Estate Taxes(Sch.IX-B)		103,186	32
33	Accrued Interest Payable	4,940	42,388	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Interdivision Payable		1,305,356	36
37	Current Portion Mortgage Payable		123,642	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 241,995	$ 1,811,627	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		8,518,112	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44	Security Deposits	59,410	59,410	44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 59,410	$ 8,577,522	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 301,405	$ 10,389,149	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,129,976	$ 1,337,597	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,431,381	$ 11,726,746	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Facility Name & ID Number Seminary Manor **#** 0047233 **Report Period Beginning:** 10/1/09 **Ending:** 9/30/10

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,468,714	1
2	Restatements (describe):		2
3	See Attached Schedule X	(19,814)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,448,900	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	681,076	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)**	$ 681,076	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,129,976	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Seminary Manor # 0047233 Report Period Beginning: 10/1/09 Ending: 9/30/10

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,859,833	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,859,833	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	129,588	6
7	Oxygen	11,828	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 141,416	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	9,040	12
13	Barber and Beauty Care	7,768	13
14	Non-Patient Meals	6,628	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	6,523	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	915	19
20	Radiology and X-Ray	132	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 31,006	23
	D. Non-Operating Revenue		
24	Contributions	3,179	24
25	Interest and Other Investment Income***	2,104	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 5,283	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Activity Fund Income		28
28a	See Att Schedule XI	3,221	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 3,221	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,040,759	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,339,022	31
32	Health Care	3,453,439	32
33	General Administration	1,478,132	33
	B. Capital Expense		
34	Ownership	936,714	34
	C. Ancillary Expense		
35	Special Cost Centers	86,128	35
36	Provider Participation Fee	66,248	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,359,683	40
41	**Income before Income Taxes (line 30 minus line 40)****	681,076	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 681,076	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. SEE ACCOUNTANTS' COMPILATION REPORT**

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

Facility Name & ID Number Seminary Manor # 0047233 Report Period Beginning: 10/1/09 Ending: 9/30/10

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,923	2,045	$ 65,306	$ 31.93	1
2	Assistant Director of Nursing			0		2
3	Registered Nurses	6,541	6,958	153,079	22.00	3
4	Licensed Practical Nurses	30,342	32,278	558,418	17.30	4
5	CNAs & Orderlies	109,030	114,925	1,068,803	9.30	5
6	CNA Trainees					6
7	Licensed Therapist	30	30	941	31.37	7
8	Rehab/Therapy Aides			0		8
9	Activity Director	125	125	1,749	13.99	9
10	Activity Assistants	7,854	8,355	81,098	9.71	10
11	Social Service Workers	1,490	1,585	19,015	12.00	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	32,232	34,290	317,981	9.27	15
16	Dishwashers					16
17	Maintenance Workers	4,277	4,550	69,620	15.30	17
18	Housekeepers	12,169	12,946	120,140	9.28	18
19	Laundry	5,763	6,131	51,808	8.45	19
20	Administrator	1,956	2,080	137,211	65.97	20
21	Assistant Administrator	1,622	1,726	27,612	16.00	21
22	Other Administrative	3,910	4,160	76,133	18.30	22
23	Office Manager					23
24	Clerical	8,104	8,622	87,279	10.12	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	2,182	2,321	20,822	8.97	31
32	Other Health Care(specify)	5,761	6,128	112,638	18.38	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	235,311	249,255	$ 2,969,653 *	$ 11.91	34

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 9,225	1-3	35
36	Medical Director		36,750	9-3	36
37	Medical Records Consultant		1,760	10-3	37
38	Nurse Consultant		2,400	10-3	38
39	Pharmacist Consultant		4,734	10-3	39
40	Physical Therapy Consultant		336,438	10a-3	40
41	Occupational Therapy Consultant		247,084	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		102,587	10a-3	43
44	Activity Consultant		0	11-3	44
45	Social Service Consultant		0	12-3	45
46	Other(specify) Dental Consultant		0	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 740,978		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Tracy Owens	Administrator	None	$ 137,211
Beverly Kenney	Asst Admin	None	27,612
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 164,823

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
RFMS, Inc.	Administrative Services	$ 171,600
McGladrey & Pullen, LLP	Accounting Services	11,497
LTC Support Services, LLC	Support Services	145,200
American Healthcare Managmt	Healthcare Services	3,530
My Innerview	Management Services	2,803
Polsinelli Shughart PC	Legal Services	1,488
Davis & Campbell, LLC	Legal Services	1,620
Spears and Spears	Legal Services	510
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 338,248

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 119,915
Unemployment Compensation Insurance	18,803
FICA Taxes	218,811
Employee Health Insurance	104,986
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401 (k)	17,966
Other Employee Benefits	2,366
TOTAL (agree to Schedule V, line 22, col.8)	$ 482,847

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	2,064
Health Care Worker Background Check	
(Indicate # of checks performed 606)	6,064
Patient Background Checks	
Advertising - Promotion	56,092
Subscriptions	2,868
IHCA Dues	4,569
Other Liceneses & Fees	2,150
Indirect Costs - See Att Sch III	2
Less: Public Relations Expense	( )
Non-allowable advertising	(56,092)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 17,717

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Staff use of personal vehicle on facility	
business and meals (under $250 per	
travel voucher)	0
Seminar Expense	400
Less: non-allowable out-of-state travel	0
Indirect costs - See Att Sch III	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 400

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Seminary Manor # 0047233 Report Period Beginning: 10/1/09 Ending: 9/30/10

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Seminary Manor # 0047233 **Report Period Beginning:** 10/1/09 **Ending:** 9/30/10

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? **6 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **36,790** 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. $ **66,248**
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.

SEE ACCOUNTANTS' COMPILATION REPORT

(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**

(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.