

		FOR BHF USE					

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**2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)**

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.

<p>I. IDPH License ID Number: <u>0047233</u></p> <p>Facility Name: <u>Seminary Manor</u></p> <p>Address: <u>2345 North Seminary</u> <u>Galesburg</u> <u>61401</u> <small>Number City Zip Code</small></p> <p>County: <u>Knox</u></p> <p>Telephone Number: <u>(309) 344-1300</u> Fax # <u>(309) 344-2473</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>7/28/2005</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT <input checked="" type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code <u>501 (c) (3)</u> </td> <td style="width:33%; border: none;"> <input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____ </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____ </td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Ron Wilson</u> Telephone Number: <u>(309) 343-1550</u> Email Address: _____</p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT <input checked="" type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code <u>501 (c) (3)</u>	<input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>10/1/10</u> to <u>9/30/11</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;">(Signed) _____ (Type or Print Name) <u>Ben Perkins</u> (Title) <u>Director of Operations</u></td> </tr> <tr> <td style="width:20%; padding: 5px;">Paid Preparer</td> <td style="padding: 5px;">(Signed) <u>See Attached Independent Accountant's Report</u> (Print Name and Title) <u>McGladrey & Pullen, LLP</u> <u>117 E. Main St., Suite 210</u> (Firm Name & Address) <u>P.O. Box 1070</u> <u>Galesburg, IL 61401</u> (Telephone) <u>(309) 342-1175</u> Fax # <u>(309) 342-7816</u></td> </tr> </table> <p align="right">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</p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Ben Perkins</u> (Title) <u>Director of Operations</u>	Paid Preparer	(Signed) <u>See Attached Independent Accountant's Report</u> (Print Name and Title) <u>McGladrey & Pullen, LLP</u> <u>117 E. Main St., Suite 210</u> (Firm Name & Address) <u>P.O. Box 1070</u> <u>Galesburg, IL 61401</u> (Telephone) <u>(309) 342-1175</u> Fax # <u>(309) 342-7816</u>
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Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Ben Perkins</u> (Title) <u>Director of Operations</u>							
Paid Preparer	(Signed) <u>See Attached Independent Accountant's Report</u> (Print Name and Title) <u>McGladrey & Pullen, LLP</u> <u>117 E. Main St., Suite 210</u> (Firm Name & Address) <u>P.O. Box 1070</u> <u>Galesburg, IL 61401</u> (Telephone) <u>(309) 342-1175</u> Fax # <u>(309) 342-7816</u>							

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Seminary Manor

0047233 Report Period Beginning: 10/1/10 Ending: 9/30/11

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	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				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF	11,308	13,645	13,312	38,265	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	11,308	13,645	13,312	38,265	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.64%

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

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

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

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

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 121 and days of care provided 9,602

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 9/30/11 Fiscal Year: 9/30/11

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

Facility Name & ID Number Seminary Manor # 0047233 Report Period Beginning: 10/1/10 Ending: 9/30/11

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
	A. General Services										
1	Dietary	342,138	41,191	9,490	392,819		392,819		392,819		1
2	Food Purchase		421,739		421,739		421,739	(7,361)	414,378		2
3	Housekeeping	122,579	49,404		171,983		171,983		171,983		3
4	Laundry	60,004	32,651		92,655		92,655		92,655		4
5	Heat and Other Utilities			148,752	148,752		148,752	182	148,934		5
6	Maintenance	69,799	49,811	60,608	180,218		180,218		180,218		6
7	Other (specify):*										7
8	TOTAL General Services	594,520	594,796	218,850	1,408,166		1,408,166	(7,179)	1,400,987		8
	B. Health Care and Programs										
9	Medical Director			34,250	34,250		34,250		34,250		9
10	Nursing and Medical Records	2,014,544	588,399	13,198	2,616,141		2,616,141		2,616,141		10
10a	Therapy			784,478	784,478		784,478		784,478		10a
11	Activities	94,299	3,943		98,242		98,242		98,242		11
12	Social Services	26,037			26,037		26,037		26,037		12
13	CNA Training										13
14	Program Transportation					3,916	3,916		3,916		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,134,880	592,342	831,926	3,559,148	3,916	3,563,064		3,563,064		16
	C. General Administration										
17	Administrative	168,813			168,813		168,813		168,813		17
18	Directors Fees							3,409	3,409		18
19	Professional Services			328,903	328,903		328,903	2,665	331,568		19
20	Dues, Fees, Subscriptions & Promotions			73,234	73,234		73,234	(54,830)	18,404		20
21	Clerical & General Office Expenses	89,658	42,080	74,208	205,946		205,946	(22,275)	183,671		21
22	Employee Benefits & Payroll Taxes			554,103	554,103		554,103		554,103		22
23	Inservice Training & Education			2,425	2,425		2,425		2,425		23
24	Travel and Seminar			1,680	1,680		1,680		1,680		24
25	Other Admin. Staff Transportation			7,832	7,832	(3,916)	3,916		3,916		25
26	Insurance-Prop.Liab.Malpractice			47,100	47,100		47,100	54,205	101,305		26
27	Other (specify):* See Att Sch V	69,316		130,509	199,825		199,825	(199,825)			27
28	TOTAL General Administration	327,787	42,080	1,219,994	1,589,861	(3,916)	1,585,945	(216,651)	1,369,294		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,057,187	1,229,218	2,270,770	6,557,175		6,557,175	(223,830)	6,333,345		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:

10/1/10

Ending:

9/30/11

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			113,849	113,849		113,849	278,946	392,795			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							430,832	430,832			32
33	Real Estate Taxes							144,600	144,600			33
34	Rent-Facility & Grounds			819,325	819,325		819,325	(819,325)				34
35	Rent-Equipment & Vehicles			33,956	33,956		33,956		33,956			35
36	Other (specify):* See Att Sch IV							8,678	8,678			36
37	TOTAL Ownership			967,130	967,130		967,130	43,731	1,010,861			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			80,505	80,505		80,505		80,505			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			6,086	6,086		6,086		6,086			41
42	Provider Participation Fee			66,248	66,248		66,248		66,248			42
43	Other (specify):* Outpatient Care			7,719	7,719		7,719		7,719			43
44	TOTAL Special Cost Centers			160,558	160,558		160,558		160,558			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,057,187	1,229,218	3,398,458	7,684,863		7,684,863	(180,099)	7,504,764			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:

10/1/10

Ending:

9/30/11

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(7,361)	V-2		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	(8,052)	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	(22,284)	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	(128,285)	V-27		24
25	Fund Raising, Advertising and Promotional	(55,067)	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	(71,870)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (292,919)		\$	30

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	105,988		34
35	Other- Attach Schedule See Att Sch III	6,832		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 112,820		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (180,099)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4
		Yes	No	Amount	Reference
38	Medically Necessary Transport.			\$	38
39					39
40	Gift and Coffee Shops				40
41	Barber and Beauty Shops				41
42	Laboratory and Radiology				42
43	Prescription Drugs				43
44					44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	TOTAL (C): (sum of lines 38-46)			\$	47

BHF USE ONLY							
48		49		50		51	

SEE ACCOUNTANTS' COMPILATION REPORT

Seminary Manor

ID# 0047233

Report Period Beginning: 10/1/10

Ending: 9/30/11

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
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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 B

Facility Name & ID Number Seminary Manor# 0047233

Report Period Beginning:

10/1/10

Ending:

9/30/11

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	105,988	0	0	0	0	0	0	0	0	0	105,988	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	105,988	0	0	0	0	0	0	0	0	0	105,988	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
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	0	105,988	0	0	0	0	0	0	0	0	0	105,988	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
None	N/A	Unlimited Development, Inc. (UDI)		See Attached Schedule I		
		Community Living Options, Inc. (CLO)				
		See Attached Schedule I for specific homes & other CLO subsidiaries				

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 Facility Rent	\$ 819,325	Galesburg North Seminary, LLC	N/A	\$ 925,313	\$ 105,988	1
2	V							2
3	V			See Att Schedule IV and Independent Accountant's Report				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		\$ 819,325			\$ 925,313	\$ * 105,988	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
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

Facility Name & ID Number Seminary Manor # 0047233 Report Period Beginning: 10/1/10 Ending: 9/30/11

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	See Attached Schedule II & III								\$ 3,409	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	\$ 3,409		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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Seminary Manor

0047233

Report Period Beginning:

10/1/10

Ending: 9/30/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2	See Att Sch II & III							6,832	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				\$	\$		\$	6,832

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Seminary Manor

0047233

Report Period Beginning:

10/1/10

Ending:

9/30/11

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										
										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			
A. Directly Facility Related																			
Long-Term																			
1	Cambridge Realty Capital					\$		\$		\$	1								
2	LTD. Of Illinois	X	Facility purchase	\$40,951.77	7/1/11		9,063,800	9,054,194	8/1/2046	4.1500	438,884	2							
3												3							
4												4							
5												5							
Working Capital																			
6	Miscellaneous	X										6							
7	Less Interest Income	X									(8,052)	7							
8												8							
9	TOTAL Facility Related			\$40,951.77		\$	9,063,800	9,054,194			\$ 430,832	9							
B. Non-Facility Related*																			
10												10							
11												11							
12												12							
13												13							
14	TOTAL Non-Facility Related					\$		\$			\$	14							
15	TOTALS (line 9+line14)					\$	9,063,800	9,054,194			\$ 430,832	15							

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 43,327 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.)

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.																						
1. Real Estate Tax accrual used on 2010 report.		\$	103,186	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.)		\$	139,846	2																				
3. Under or (over) accrual (line 2 minus line 1).		\$	36,660	3																				
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	107,940	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.		\$	144,600	7																				
Real Estate Tax History:																								
Real Estate Tax Bill for Calendar Year:	2006	118,032	8	<table border="1" style="width: 100%;"> <tr> <td colspan="3" style="text-align: center;">FOR BHF USE ONLY</td> </tr> <tr> <td style="text-align: center;">13</td> <td>FROM R. E. TAX STATEMENT FOR 2010</td> <td style="text-align: right;">\$</td> <td style="text-align: center;">13</td> </tr> <tr> <td style="text-align: center;">14</td> <td>PLUS APPEAL COST FROM LINE 5</td> <td style="text-align: right;">\$</td> <td style="text-align: center;">14</td> </tr> <tr> <td style="text-align: center;">15</td> <td>LESS REFUND FROM LINE 6</td> <td style="text-align: right;">\$</td> <td style="text-align: center;">15</td> </tr> <tr> <td style="text-align: center;">16</td> <td>AMOUNT TO USE FOR RATE CALCULATION</td> <td style="text-align: right;">\$</td> <td style="text-align: center;">16</td> </tr> </table>		FOR BHF USE ONLY			13	FROM R. E. TAX STATEMENT FOR 2010	\$	13	14	PLUS APPEAL COST FROM LINE 5	\$	14	15	LESS REFUND FROM LINE 6	\$	15	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16
FOR BHF USE ONLY																								
13	FROM R. E. TAX STATEMENT FOR 2010	\$	13																					
14	PLUS APPEAL COST FROM LINE 5	\$	14																					
15	LESS REFUND FROM LINE 6	\$	15																					
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16																					
	2007	129,586	9																					
	2008	135,794	10																					
	2009	141,411	11																					
	2010	139,846	12																					
This facility was purchased from an unrelated for-profit entity during 2005. A tax exemption has not yet been obtained.																								
Amount accrued includes the taxes for 9 months based on fiscal year end. Estimate is based on prior year tax bill.																								
Taxes paid during year represents the entire 2010 bill.																								

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.

SEE ACCOUNTANTS' COMPILATION REPORT

2010 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 2010 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 2010.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>99-02-101-045</u>	<u>HAWTHORNE CENTRE SUB</u>	\$ <u>139,846.00</u>	\$ <u>139,846.00</u>
2. _____	<u>LOT 1 (EX E50 FT) BLK 1 &</u>	\$ _____	\$ _____
3. _____	<u>HAWTHORNE CENTRE RESUB</u>	\$ _____	\$ _____
4. _____	<u>NO - 5 PT LOT 6 - BEG NW</u>	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>139,846.00</u>	\$ <u>139,846.00</u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation 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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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:

10/1/10

Ending:

9/30/11

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

None

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

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

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

XI. OWNERSHIP COSTS:

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Seminary Manor

0047233

Report Period Beginning:

10/1/10

Ending:

9/30/11

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-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	120		2005		\$ 9,633,067	\$ 240,827	40	\$ 240,827	\$	\$ 1,485,098	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		Fire Door Closers	2005		3,059	204	15	204		1,190	9
10		A/C, Sign, Concrete, Asphalt, Door, Dining rm addn, Alarm	2006		74,961	7,195	8-15 yrs	7,195		39,721	10
11		Modem	2006			533	5	533			11
12		AC, Vinyl, Cabinetry, Sidewalk, Roof/deck repair, window treatments	2007		123,842	12,527	5-15 yrs	12,527		58,478	12
13		Roof	2008		10,625	1,063	10	1,063		3,719	13
14		Roof	2008		15,195	1,519	10	1,519		5,318	14
15		Roof	2008		15,580	1,558	10	1,558		5,323	15
16		Roof	2008		4,633	463	10	463		1,583	16
17		Fire Dampers	2008		6,438	644	10	644		2,039	17
18		Condensor	2008		3,548	236	15	236		788	18
19		Sidewalks	2008		2,887	193	15	193		626	19
20		Prime Walls/Paint	2008		4,560	912	5	912		2,812	20
21		Condensing units/Regrigeration Piping	2008		6,352	423	15	423		1,623	21
22		Air Conditioner	2008		3,408	682	5	682		2,613	22
23		Hand rail	2008		2,781	186	15	186		711	23
24		Double door with Sidelights	2008		12,030	1,203	10	1,203		4,612	24
25		Roof Repairs	2008		25,054	2,505	10	2,505		8,769	25
26		Roof Repairs - Garage	2008		4,550	455	10	455		1,479	26
27		Sprinklers	2008		2,726	109	25	109		354	27
28		Lighting pole	2009		6,677	668	10	668		2,003	28
29		Replace wall/ceiling sheetrock, tile, paint	2009		39,005	3,251	12	3,251		8,939	29
30		Roof replacement	2009		9,574	957	10	957		2,792	30
31		Rubber flooring	2009		14,397	1,440	10	1,440		4,199	31
32		Light posts concrete	2009		3,690	246	15	246		738	32
33		Parking lot light poles	2009		6,505	434	15	434		1,301	33
34		Parking lot (asphalt)	2009		40,752	5,094	8	5,094		15,282	34
35		Tile	2009		4,267	213	20	213		533	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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Seminary Manor

0047233

Report Period Beginning:

10/1/10

Ending:

9/30/11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	Waterheater	2009	\$ 7,074	\$ 708	10	\$ 708		\$ 1,710	37
38	Shower room	2009	30,990	2,066	15	2,066		5,165	38
39	Seminary manor PT Addition (Contracted Total)	2009	152,233	6,089	25	6,089		17,253	39
40	Seminary Manor Garden Court Addition (Contracted Total)	2009	131,812	5,273	25	5,273		14,939	40
41	Concrete Parking Lot & Sidewalk	2009	12,869	858	15	858		2,002	41
42	Water Heater	2010	3,750	375	10	375		406	42
43	Water Heater	2010	3,750	375	10	375		375	43
44	Carpet - Bounce Back	2011	25,627	427	5	427		427	44
45	Sem Manor Public BR-floor/wallpaper/vanity/faucets/mirrors/toile	2011	15,530	108	12	108		108	45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 10,463,798	\$ 302,019		\$ 302,019		\$ 1,705,028	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	\$ 669,279	\$ 68,035	\$ 68,035	\$	3-15 yrs	\$ 345,208	71
72	Current Year Purchases	90,724	10,002	10,002		3-15 yrs	10,002	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 760,003	\$ 78,037	\$ 78,037	\$		\$ 355,210	75

D. Vehicle Costs. (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	\$ 12,739	\$ 12,739	\$	4 yrs	\$ 39,274	76
77										77
78										78
79										79
80	TOTALS			\$ 50,950	\$ 12,739	\$ 12,739	\$		\$ 39,274	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)	\$ 11,561,751	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 392,795	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 392,795	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)	\$ 2,099,512	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	\$	\$ 21,200	86
87	2006 Toyota Corolla - 2006	14,900		14,900	87
88					88
89					89
90					90
91	TOTALS	\$ 36,100	\$	\$ 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.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ <u>See Attached</u>			3
4	Additions				<u>Schedule IV</u>			4
5					<u>Related Party</u>			5
6					<u>Lease</u>			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: \$ 33,956 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

10. Effective dates of current rental agreement:

Beginning _____
Ending _____

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

	Fiscal Year Ending	Annual Rent
12.	<u>/2012</u>	\$ <u>N/A</u>
13.	<u>/2013</u>	\$ <u>N/A</u>
14.	<u>/2014</u>	\$ <u>N/A</u>

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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	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

Facility Name & ID Number Seminary Manor# 0047233Report Period Beginning: 10/1/10Ending: 9/30/11

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 9/30/11

(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	\$ 23,578	\$ 170,810	1
2	Cash-Patient Deposits	14,146	14,146	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>68,105</u>)	1,139,247	1,139,247	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	112,809	161,421	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Att Sch VII</u>	1,540,507	1,565,138	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,830,287	\$ 3,050,762	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	804,478	804,478	15
16	Equipment, at Historical Cost	492,120	847,053	16
17	Accumulated Depreciation (book methods)	(419,386)	(2,135,612)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Att Sch VII</u>		759,391	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 877,212	\$ 10,221,630	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,707,499	\$ 13,272,392	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 191,642	\$ 191,642	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	14,146	14,146	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	64,902	64,902	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,745	3,745	31
32	Accrued Real Estate Taxes(Sch.IX-B)		107,940	32
33	Accrued Interest Payable	4,940	36,252	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Interdivision Payable</u>		1,305,356	36
37	<u>Current portion of long term payable</u>		117,898	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 279,375	\$ 1,841,881	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		8,936,296	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44	<u>Security Deposits</u>	55,675	55,675	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 55,675	\$ 8,991,971	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 335,050	\$ 10,833,852	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,372,449	\$ 2,438,540	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,707,499	\$ 13,272,392	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,129,976	1
2	Restatements (describe):		2
3	See Attached Schedule X	(11,755)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,118,221	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,254,228	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)	\$ 1,254,228	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)	\$ 3,372,449	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Seminary Manor# 0047233Report Period Beginning: 10/1/10Ending: 9/30/11

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 8,694,749	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,694,749	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	173,871	6
7	Oxygen	25,036	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 198,907	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	9,108	12
13	Barber and Beauty Care	7,779	13
14	Non-Patient Meals	7,361	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	3,741	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	348	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 28,337	23
D. Non-Operating Revenue			
24	Contributions	4,090	24
25	Interest and Other Investment Income***	8,052	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 12,142	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Activity Fund Income		28
28a	See Att Schedule XI	4,956	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 4,956	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,939,091	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,408,166	31
32	Health Care	3,559,148	32
33	General Administration	1,589,861	33
B. Capital Expense			
34	Ownership	967,130	34
C. Ancillary Expense			
35	Special Cost Centers	94,310	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)*	\$ 7,684,863	40
41	Income before Income Taxes (line 30 minus line 40)**	1,254,228	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,254,228	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:

10/1/10

Ending:

9/30/11

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	1,905	2,049	\$ 67,608	\$ 33.00	1
2	Assistant Director of Nursing	1,821	1,958	47,288	24.15	2
3	Registered Nurses	4,533	4,874	99,437	20.40	3
4	Licensed Practical Nurses	30,037	32,297	566,496	17.54	4
5	CNAs & Orderlies	108,894	117,090	1,099,479	9.39	5
6	CNA Trainees					6
7	Licensed Therapist			0		7
8	Rehab/Therapy Aides			0		8
9	Activity Director			0		9
10	Activity Assistants	8,767	9,427	94,299	10.00	10
11	Social Service Workers	1,969	2,117	26,037	12.30	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	35,711	38,399	342,138	8.91	15
16	Dishwashers					16
17	Maintenance Workers	4,092	4,400	69,799	15.86	17
18	Housekeepers	12,284	13,209	122,579	9.28	18
19	Laundry	6,474	6,961	60,004	8.62	19
20	Administrator	1,956	2,080	142,381	68.45	20
21	Assistant Administrator	1,855	1,995	26,432	13.25	21
22	Other Administrative	4,159	4,472	69,316	15.50	22
23	Office Manager					23
24	Clerical	6,157	6,621	89,658	13.54	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	2,263	2,433	21,920	9.01	31
32	Other Health Care(specify)	5,720	6,151	112,316	18.26	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	238,597	256,533	\$ 3,057,187 *	\$ 11.92	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	\$ 9,490	1-3	35
36	Medical Director	34,250	9-3	36
37	Medical Records Consultant	1,760	10-3	37
38	Nurse Consultant	4,755	10-3	38
39	Pharmacist Consultant	6,683	10-3	39
40	Physical Therapy Consultant	413,036	10a-3	40
41	Occupational Therapy Consultant	278,106	10a-3	41
42	Respiratory Therapy Consultant	0	10a-3	42
43	Speech Therapy Consultant	93,336	10a-3	43
44	Activity Consultant		11-3	44
45	Social Service Consultant		12-3	45
46	Other(specify)	0	10-3	46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 841,416		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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Seminary Manor

0047233

Report Period Beginning: 10/1/10

Ending: 9/30/11

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			Ownership %	Amount	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function				Description	Amount	Description	Amount		
Tracy Owens	Administrator	None	\$ 142,381	Workers' Compensation Insurance	\$ 143,797	IDPH License Fee	\$			
Beverly Kenney	Asst Admin	None	26,432	Unemployment Compensation Insurance	29,447	Advertising: Employee Recruitment				
				FICA Taxes	225,471	Health Care Worker Background Check				
				Employee Health Insurance	122,143	(Indicate # of checks performed <u>223</u>)		7,161		
				Employee Meals		Patient Background Checks <u>100</u>		1,000		
				Illinois Municipal Retirement Fund (IMRF)*		Advertising - Promotion		55,067		
				401 (k)	29,672	Subscriptions		1,280		
				Other Employee Benefits	3,573	IHCA Dues		4,200		
						Other Licenses & Fees		4,526		
						Indirect Costs - See Att Sch III		237		
						Less: Public Relations Expense	(
						Non-allowable advertising		(55,067)		
						Yellow page advertising	(
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 168,813	TOTAL (agree to Schedule V, line 22, col.8)			\$ 554,103	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 18,404
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**			
Description			Amount	Description	Line #	Amount	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	1,680		
							Less: non-allowable out-of-state travel	0		
							Indirect costs - See Att Sch III	0		
							Entertainment Expense	(
							(agree to Sch. V, line 24, col. 8)			
TOTAL (agree to Schedule V, line 17, col. 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 328,903	TOTAL			\$	TOTAL		\$ 1,680

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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								
													Amount of Expense Amortized Per Year							
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010
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# 0047233Report Period Beginning: 10/1/10Ending: 9/30/11**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? 7 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 56,003 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.
- (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. \$ 7,361
- (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.

SEE ACCOUNTANTS' COMPILATION REPORT