FOR BHF USE

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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.

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

I. IDPH License ID Number: 0034066

Facility Name: St. Mary's Square Living Center

Address: 239 South Cherry (Number) Galesburg (City) 61401 (Zip Code)

County: Knox

Telephone Number: (309) 343-4104 **Fax #** (309) 343-4118

HFS ID Number:

Date of Initial License for Current Owners: 7/15/88

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 07/01/2011 to 06/30/2012 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name) Bobby Dillard
(Title) Administrator

Paid Preparer

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

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

Facility Name & ID Number St. Mary's Square Living Center # 0034066 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	255	Intermediate (ICF)	255	93,330	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	255	TOTALS	255	93,330	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					8
9	SNF/PED					9
10	ICF	73,999	0		73,999	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	73,999			73,999	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.29%

D. How many bed-hold days during this year were paid by the Department?
1,786 (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 04/01/80

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 7/15/88 NO [ ]

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

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

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

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

Tax Year: 06/30/2012 Fiscal Year: 06/30/2012

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

Facility Name & ID Number St. Mary's Square Living Center # 0034066 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

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	417,750	29,572	5,441	452,763		452,763		452,763			1
2	Food Purchase		466,334		466,334	(12,076)	454,258		454,258			2
3	Housekeeping	319,263	55,078		374,341		374,341		374,341			3
4	Laundry	163,401	64,210		227,611		227,611		227,611			4
5	Heat and Other Utilities			218,893	218,893		218,893		218,893			5
6	Maintenance	148,831	38,611	104,860	292,302		292,302		292,302			6
7	Other (specify):*											7
8	TOTAL General Services	1,049,245	653,805	329,194	2,032,244	(12,076)	2,020,168		2,020,168			8
	B. Health Care and Programs											
9	Medical Director			21,650	21,650		21,650		21,650			9
10	Nursing and Medical Records	3,829,414	217,358	36,057	4,082,829		4,082,829		4,082,829			10
10a	Therapy			11,888	11,888		11,888		11,888			10a
11	Activities	84,102	9,319	36,786	130,207		130,207	(26,006)	104,201			11
12	Social Services	89,619		539	90,158		90,158		90,158			12
13	CNA Training	78,926			78,926		78,926		78,926			13
14	Program Transportation					12,412	12,412		12,412			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	4,082,061	226,677	106,920	4,415,658	12,412	4,428,070	(26,006)	4,402,064			16
	C. General Administration											
17	Administrative	96,271			96,271		96,271		96,271			17
18	Directors Fees			16,919	16,919		16,919		16,919			18
19	Professional Services			624,003	624,003		624,003	(1,670)	622,333			19
20	Dues, Fees, Subscriptions & Promotions			25,967	25,967		25,967		25,967			20
21	Clerical & General Office Expenses	175,446	50,047	51,773	277,266		277,266	(35,715)	241,551			21
22	Employee Benefits & Payroll Taxes			1,303,502	1,303,502	12,076	1,315,578		1,315,578			22
23	Inservice Training & Education			146	146		146		146			23
24	Travel and Seminar			1,305	1,305		1,305		1,305			24
25	Other Admin. Staff Transportation			24,823	24,823	(12,412)	12,411		12,411			25
26	Insurance-Prop.Liab.Malpractice			69,834	69,834		69,834	35,521	105,355			26
27	Other (specify):* See Att Sch VIII											27
28	TOTAL General Administration	271,717	50,047	2,118,272	2,440,036	(336)	2,439,700	(1,864)	2,437,836			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,403,023	930,529	2,554,386	8,887,938		8,887,938	(27,870)	8,860,068			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number St. Mary's Square Living Center #0034066 **Report Period Beginning:** 07/01/2011 **Ending:** 06/30/2012

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			143,886	143,886		143,886	213,912	357,798			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							292,556	292,556			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			576,000	576,000		576,000	(576,000)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* See Att Sch III							11,126	11,126			36
37	**TOTAL Ownership**			719,886	719,886		719,886	(58,406)	661,480			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			578,840	578,840		578,840		578,840			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			578,840	578,840		578,840		578,840			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,403,023	930,529	3,853,112	10,186,664		10,186,664	(86,276)	10,100,388			45

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

Facility Name & ID Number St. Mary's Square Living Center # 0034066 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

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	(9,564)	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	(35,715)	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		V-27		24
25	Fund Raising, Advertising and Promotional		V-20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Att Sch IV	(27,676)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (72,955)		$	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)	(13,321)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (13,321)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (86,276)		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

St. Mary's Square Living Center

ID# 0034066

Report Period Beginning: 07/01/2011

Ending: 06/30/2012

	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 St. Mary's Square Living Center **#** 0034066 **Report Period Beginning:** 07/01/2011 **Ending:** 06/30/2012

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 St. Mary's Square Living Center **#** 0034066 **Report Period Beginning:** 07/01/2011 **Ending:** 06/30/2012

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

	Capital Expense D. Ownership	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)	
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	(13,321)	0	0	0	0	0	0	0	0	0	(13,321)	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	(13,321)	0	0	0	0	0	0	0	0	0	(13,321)	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	(13,321)	0	0	0	0	0	0	0	0	0	(13,321)	45

Facility Name & ID Number St. Mary's Square Living Center # 0034066 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

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
Community Residential Centers, Inc.				CRC Cherry Street Facility, LLC		
(Non-profit Organization)					Galesburg	Lessor
				LTC Suport Services, LLC		
					Galesburg	Support Services

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	Rent	$ 576,000	CRC Cherry Street Facility, LLC	N/A	$ 562,679	$ (13,321)	1
2	V				See Att Sch II				2
3	V								3
4	V								4
5	V				LTC Support Services, LLC				5
6	V				See Independent Accountant's Report				6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 576,000			$ 562,679	$ * (13,321)	14

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

Facility Name & ID Number St. Mary's Square Living Center # 0034066 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

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 St. Mary's Square Living Center # 0034066 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

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	Stanley Sydlowski, D.D.S.	President	Director	None	N/A	N/A	N/A	Board mtgs	$ 4,000	18-3	1
2	Charles D. Westbay	Secretary	Director	None	N/A	N/A	N/A	Board mtgs	4,000	18-3	2
3	Gary Bruington	Director	Director	None	N/A	N/A	N/A	Board mtgs	4,000	18-3	3
4	David Beversdorf	Director	Director	None	N/A	N/A	N/A	Board mtgs	4,000	18-3	4
5											5
6						Training and meeting expenses			919		6
7						Less: Non-allowable out-of-state travel					7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 16,919		13

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

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

Facility Name & ID Number St. Mary's Square Living Center # 0034066 Report Period Beginning: 07/01/2011 Ending: 6/30/2012

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 [X]

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number (
Fax Number (

	1 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										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number St. Mary's Square Living Center # 0034066 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

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**		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	Berkadia Commercial						$	$			$	1
2	Mortgage Corp		X	Facility Purchase	$39,717.00	09/01/2003	6,164,400	4,954,904	10/1/2028	6.0000	302,120	2
3												3
4												4
5												5
	Working Capital											
6												6
7	Interest Income		X	Page 5, Line 10							(9,564)	7
8												8
9	TOTAL Facility Related				$39,717.00		$ 6,164,400	$ 4,954,904			$ 292,556	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 6,164,400	$ 4,954,904			$ 292,556	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 25,171 Line # V-26

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

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

Facility Name & ID Number St. Mary's Square Living Center # 0034066 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(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.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2007	N/A	8
	2008	N/A	9
	2009	N/A	10
	2010	N/A	11
	2011	N/A	12

Real estate taxes are not assessed due to the facility receiving an exemption in 2007 eff. For the calendar yr. 2006.
Therefore, no accrual for the real estate tax is required.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	$	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.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME St. Mary's Square Living Center COUNTY Knox

FACILITY IDPH LICENSE NUMBER 0034066

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2011 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 2011.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

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 _____ 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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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

Facility Name & ID Number St. Mary's Square Living Center # 0034066 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 131,192 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 4 and 5

C. Does the Operating Entity? [ ] (a) Own the Facility [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 [ ] (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:
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	120,682	2003	$ 180,000	1
2	Facility	11,210	2003	4,000	2
3	TOTALS	131,892		$ 184,000	3

Facility Name & ID Number St. Mary's Square Living Center # 0034066 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	255		2003		$ 6,220,000	$ 207,333	30	$ 207,333	$	$ 1,814,167	4
5			2003		131,518	6,579	20	6,579		56,446	5
6											6
7											7
8											8
	Improvement Type**										
9	Garage addition, elevator			1988	39,318		15-20 yrs			39,318	9
10	Sprinkler, Roof repair			1989	29,422	62	20-25 yrs	62		29,318	10
11	Water chiller repair, boiler repair			1990	11,633		15-20 yrs			11,633	11
12	Roof repair, roofing			1991	49,477	37	20	37		49,477	12
13	Heater, furnace			1992	2,505		15			2,505	13
14	Window, sidewalk			1993	7,150		15			7,150	14
15	Paving, plumbing, boiler equipment, roofing			1994	30,695	402	10-20 yrs	402		29,830	15
16	A/C chiller, tuckpointing, roofing, transformer, elvator equip			1995	102,052	3,635	15-25 yrs	3,635		77,585	16
17	Alarm electric work, water heater, A.C. units, Stucco work			1996	59,408	1,074	10-25 yrs	1,074		51,344	17
18	A/C Units, fire alram system, paving			1997	62,969	302	8-15 yrs	302		62,969	18
19	Fire alarm, condesate ret. System			1998	10,166	227	10-15 yrs	227		9,863	19
20	Coils & stats, fire alarm, commercial door			1999	62,346	267	10-15 yrs	267		61,724	20
21	Kitchen upgrade, air conditioner rep, countertop, hall handle rep, HVAC			2000	30,547	1,445	10-15 yrs	1,445		26,413	21
22	Patio, Elevator renovation			2002	77,220	3,861	20	3,861		37,587	22
23	Air handler, Concrete construction, Vinyl flooring, patio constr.			2003	46,624	2,656	10-20 yrs	2,656		24,037	23
24	2004 Additions			2004	351,219	23,113	10-20 yrs	23,113		182,894	24
25	2005 Additions			2005	39,174	3,864	10	3,864		27,351	25
26	Sprinkler system			2006	25,839	1,722	15	1,722		10,479	26
27	Elevator, A/C, door closers, shower rm rpr, reclining air tub, water heater			2008	67,213	5,094	10-20 yrs	5,094		19,748	27
28	New valve on elevator			2009	12,644	632	20	632		2,160	28
29	Generator back-up freezer/refrigerator			2009	5,610	1,122	5	1,122		3,834	29
30	Electric work - elevator			2009	4,600	230	20	230		767	30
31	Elevator			2009	77,440	3,872	20	3,872		12,584	31
32	Circuit and well pump installation			2009	5,387	269	20	269		853	32
33	3rd floor shower remodel (drains/plumbing/showers/doors/tile)			2009	17,985	900	20	900		2,848	33
34	Tuck pointing and foundation repair			2009	18,800	940	20	940		2,898	34
35	Fire alarm			2009	3,293	330	10	330		1,015	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 St. Mary's Square Living Center # 0034066 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	Door closures - part of alarm system	2009	$ 4,134	$ 276	15	$ 276	$	$ 781	37
38	Rewire Elevator Controllers	2010	5,871	294	20	294		734	38
39	Water Heater	2010	5,698	570	10	570		1,282	39
40	Boiler Repairs	2010	4,394	439	10	439		915	40
41	Bathroom remodels - walls/floors/showers/toilets/cabinets/sink/cou	2010	137,256	11,438	12	11,438		23,829	41
42	Door Closers	2010	2,852	190	15	190		333	42
43	Tuck Pointing and caulking on exterior of building	2010	5,140	257	20	257		450	43
44	Bathroom remodel (walls/paint/plumbing/tile)	2010	67,590	5,633	12	5,633		8,919	44
45	Hydraulic Piston	2010	18,620	931	20	931		1,552	45
46	Bathroom #8 Remodel (walls/tile/shower stalls/drains/caulk)	2011	13,649	1,137	12	1,137		1,611	46
47	2 Boilers	2011	45,335	2,266	20	2,266		2,833	47
48	5 Door Closers	2012	3,153	53	10	53		53	48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 7,915,946	$ 293,452		$ 293,452	$	$ 2,702,089	70

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

Facility Name & ID Number St. Mary's Square Living Center # 0034066 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

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	$ 514,582	$ 37,840	$ 37,840	$	5-20yrs	$ 355,393	71
72	Current Year Purchases	14,425	918	918		12 yrs	918	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 529,007	$ 38,758	$ 38,758	$		$ 356,311	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	See attached Schedule I	See attaached Schedule I	See Attached	$ 240,125	$ 25,588	$ 25,588	$	4 yrs	$ 238,675	76
77			Schedule I							77
78										78
79										79
80	TOTALS			$ 240,125	$ 25,588	$ 25,588	$		$ 238,675	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 8,869,078	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 357,798	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 357,798	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)	$ 3,297,075	85	

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	Building Remodel	$ 90,916	92
93			93
94			94
95		$ 90,916	95

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

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

Facility Name & ID Number St. Mary's Square Living Center # 0034066 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

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

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

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.	/2013	$
13.	/2014	$
14.	/2015	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ N/A Description: N/A Facility owned
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number St. Mary's Square Living Center # 0034066 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

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? [X] YES [ ] 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	X
IN OTHER FACILITY	
COMMUNITY COLLEGE	
HOURS PER CNA	138

3. CLINICAL PORTION:

IN-HOUSE PROGRAM	
IN OTHER FACILITY	
HOURS PER CNA	

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)		78,926		78,926
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$ 78,926	$	$ 78,926
10	SUM OF line 9, col. 1 and 2 (e)	$ 78,926			

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	42
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	42

(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.

Facility Name & ID Number St. Mary's Square Living Center # 0034066 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

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.

STATE OF ILLINOIS

Facility Name & ID Number St. Mary's Square Living Center # 0034066 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/2012 (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	$ 912,281	$ 965,709	1
2	Cash-Patient Deposits	27,037	27,037	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 20,000)	2,636,967	2,636,967	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	59,564	76,173	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Other Receivable	29,216	29,216	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,665,065	$ 3,735,102	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	10,000	10,000	12
13	Land		184,000	13
14	Buildings, at Historical Cost		6,351,518	14
15	Leasehold Improvements, at Historical Cost	1,564,428	1,564,428	15
16	Equipment, at Historical Cost	769,132	769,132	16
17	Accumulated Depreciation (book methods)	(1,426,462)	(3,297,075)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe CIP	90,916	90,916	22
23	Other(specify): See Att Sch V		1,000,077	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,008,014	$ 6,672,996	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,673,079	$ 10,408,098	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 258,429	$ 258,429	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	27,037	27,037	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	442,601	442,601	30
31	Accrued Taxes Payable (excluding real estate taxes)	13,004	13,004	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable		24,775	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accr Health Insurance Assessment	62,831	62,831	36
37	Current Maturities of Mortgage		184,328	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 803,902	$ 1,013,005	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,850,000	1,850,000	39
40	Mortgage Payable		4,770,576	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,850,000	$ 6,620,576	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,653,902	$ 7,633,581	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,019,177	$ 2,774,517	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,673,079	$ 10,408,098	48

*(See instructions.)

Facility Name & ID Number St. Mary's Square Living Center **#** 0034066 **Report Period Beginning:** 07/01/2011 **Ending:** 06/30/2012

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,611,098	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,611,098	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(591,921)	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)**	$ (591,921)	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)**	$ 2,019,177	24	*

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

Facility Name & ID Number St. Mary's Square Living Center # 0034066 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 9,460,376	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 9,460,376	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	78,926	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 78,926	23
	D. Non-Operating Revenue		
24	Contributions	16,940	24
25	Interest and Other Investment Income***	9,564	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 26,504	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)	2,931	27
28	See Att Sch VI	26,006	28
28a	See Att Sch IX for Line 27		28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 28,937	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,594,743	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,032,244	31
32	Health Care	4,415,658	32
33	General Administration	2,440,036	33
	B. Capital Expense		
34	Ownership	719,886	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	578,840	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,186,664	40
41	**Income before Income Taxes (line 30 minus line 40)****	(591,921)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (591,921)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 7,952,649	44
45	Private Pay - Net Inpatient Revenue	1,507,727	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 9,460,376	49

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

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

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

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

Facility Name & ID Number St. Mary's Square Living Center # 0034066 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

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	1,984	2,133	$ 59,733	$ 28.00	1
2	Assistant Director of Nursing	2,000	2,150	43,004	20.00	2
3	Registered Nurses	5,489	5,902	113,494	19.23	3
4	Licensed Practical Nurses	45,693	49,132	792,992	16.14	4
5	CNAs & Orderlies	205,832	223,730	2,297,710	10.27	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	5,971	6,420	84,102	13.10	9
10	Activity Assistants					10
11	Social Service Workers	5,915	6,360	89,619	14.09	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	43,899	47,203	417,750	8.85	15
16	Dishwashers					16
17	Maintenance Workers	7,955	8,554	148,831	17.40	17
18	Housekeepers	29,751	31,990	319,263	9.98	18
19	Laundry	14,942	16,067	163,401	10.17	19
20	Administrator	1,934	2,080	96,271	46.28	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	13,928	14,976	175,446	11.72	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	39,392	42,358	584,110	13.79	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,732	1,862	17,297	9.29	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	426,417	460,917	$ 5,403,023 *	$ 11.72	34

* 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	***	$ 5,441	1-3	35
36	Medical Director	***	21,650	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant	***	0	10-3	38
39	Pharmacist Consultant	***	13,827	10-3	39
40	Physical Therapy Consultant	***	5,763	10a-3	40
41	Occupational Therapy Consultant	***	3,056	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	***	3,069	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant	***	539	12-3	45
46	Other(specify) Dental	***	6,465	10-3	46
47	Psychological Consultant	***	15,765	10-3	47
48	***Monthly Fee				48
49	TOTAL (lines 35 - 48)		$ 75,575		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
Bobby Dillard	Administrator	None	$ 96,271
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 96,271

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	$ 279,510
LTC Support Services, LLC	Support Services	81,000
McGladrey LLP	Accounting Services	142,470
Margel Petticord	Accounting Services	1,512
Blake Law Office	Legal Services	25
Crain, Miller & Wernsman, LTD	Legal Services	36,504
Davis & Campbell, LLC	Legal Services	125
Duane Morris LLP	Legal Services	36,564
MPRO	Legal Services	2,460
Polsinelli Shugart PC	Legal Services	43,833
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 624,003

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 267,112
Unemployment Compensation Insurance	7,114
FICA Taxes	405,654
Employee Health Insurance	565,259
Employee Meals	12,076
Illinois Municipal Retirement Fund (IMRF)*	
401(k)	47,003
Other Employee Benefits	11,360
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,315,578

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	15,638
Health Care Worker Background Check	3,247
(Indicate # of checks performed 100)	
Patient Background Checks 12	
Subscriptions	6,629
Advertising - Promotional	
Other Licenses & Fees	453
Less: Public Relations Expense	( )
Non-allowable advertising	(0)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 25,967

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Staff use of personal vehicle on facility	
business and means (under $250 per	
travel voucher)	1,305
Seminar Expense	
Less: non-allowable out-of-state-travel	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,305

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number St. Mary's Square Living Center # 0034066 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

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		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number St. Mary's Square Living Center # 0034066 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **12 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **65,932** 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. $ **578,840**
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. $ **12,076** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **McGladrey LLP**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.