FOR BHF USE

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2013
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2013)

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.

I. IDPH License ID Number: 0034066

Facility Name: St Marys Square Living Ctr

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 7/1/2012 to 6/30/2013 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name) Ben Strong
(Title) Regional Director

Paid Preparer
(Signed) (Date)
(Print Name and Title) Larry Templin, Partner
(Firm Name & Address) Templin Healthcare Accounting Services, LLP, PO Box 9, Dunlap, IL 61525
(Telephone) (630) 361-2868 Fax # ( )

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 Marys Square Living Ctr # 0034066 Report Period Beginning: 7/1/2012 Ending: 6/30/2013

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	67,116			67,116	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	67,116			67,116	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 72.11%

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

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X] Non-allowable costs have been eliminated in Schedule V, Column 7

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

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

Tax Year: 6/30/2013 Fiscal Year: 6/30/2013

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

Facility Name & ID Number St Marys Square Living Ctr # 0034066 Report Period Beginning: 7/1/2012 Ending: 6/30/2013

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	392,441	31,259	6,623	430,323		430,323		430,323			1
2	Food Purchase		432,453		432,453		432,453	(14,261)	418,192			2
3	Housekeeping	302,448	45,519		347,967		347,967		347,967			3
4	Laundry	178,952	39,994	14	218,960		218,960		218,960			4
5	Heat and Other Utilities			273,388	273,388		273,388		273,388			5
6	Maintenance	165,654	33,442	93,661	292,757		292,757		292,757			6
7	Other (specify):*											7
8	TOTAL General Services	1,039,495	582,667	373,686	1,995,848		1,995,848	(14,261)	1,981,587			8
	B. Health Care and Programs											
9	Medical Director			21,650	21,650		21,650		21,650			9
10	Nursing and Medical Records	3,745,579	207,398	33,864	3,986,841		3,986,841		3,986,841			10
10a	Therapy			7,275	7,275		7,275		7,275			10a
11	Activities	79,510	7,739	15,509	102,758		102,758		102,758			11
12	Social Services	77,694		506	78,200		78,200		78,200			12
13	CNA Training	120,187			120,187		120,187		120,187			13
14	Program Transportation			16,745	16,745		16,745		16,745			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	4,022,970	215,137	95,549	4,333,656		4,333,656		4,333,656			16
	C. General Administration											
17	Administrative	98,272			98,272		98,272		98,272			17
18	Directors Fees			19,800	19,800		19,800		19,800			18
19	Professional Services			532,110	532,110		532,110	36,787	568,897			19
20	Dues, Fees, Subscriptions & Promotions			32,375	32,375		32,375	250	32,625			20
21	Clerical & General Office Expenses	175,243	46,907	14,135	236,285		236,285	132	236,417			21
22	Employee Benefits & Payroll Taxes			1,225,565	1,225,565		1,225,565		1,225,565			22
23	Inservice Training & Education			1,177	1,177		1,177		1,177			23
24	Travel and Seminar			2,336	2,336		2,336		2,336			24
25	Other Admin. Staff Transportation			7,136	7,136		7,136		7,136			25
26	Insurance-Prop.Liab.Malpractice			59,862	59,862		59,862	33,827	93,689			26
27	Other (specify):*											27
28	TOTAL General Administration	273,515	46,907	1,894,496	2,214,918		2,214,918	70,996	2,285,914			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,335,980	844,711	2,363,731	8,544,422		8,544,422	56,735	8,601,157			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 Marys Square Living Ctr #0034066 Report Period Beginning: 7/1/2012 Ending: 6/30/2013

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			114,853	114,853		114,853	213,912	328,765			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							300,352	300,352			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):*											36
37	**TOTAL Ownership**			690,853	690,853		690,853	(61,736)	629,117			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		1,260		1,260		1,260	(1,260)				41
42	Provider Participation Fee			567,412	567,412		567,412		567,412			42
43	Other (specify):* Non-allowable Costs			680	680		680	(680)				43
44	**TOTAL Special Cost Centers**		1,260	568,092	569,352		569,352	(1,940)	567,412			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,335,980	845,971	3,622,676	9,804,627		9,804,627	(6,941)	9,797,686			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 Marys Square Living Ctr # 0034066 Report Period Beginning: 7/1/2012 Ending: 6/30/2013

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				9
10	Interest and Other Investment Income	(1,211)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(9)	43		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	(671)	43		24
25	Fund Raising, Advertising and Promotional				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 Page 5A	(15,521)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (17,412)		$	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)	10,471		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 10,471		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (6,941)		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.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

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St Marys Square Living Ctr

ID# **0034066**

Report Period Beginning: **7/1/2012**

Ending: **6/30/2013**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Offset Vending Machine Income	$ (14,261)	2	1
2	Offset Store Income	(1,260)	41	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**	(15,521)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number St Marys Square Living Ctr **#** 0034066 **Report Period Beginning:** 7/1/2012 **Ending:** 6/30/2013

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	(14,261)	0	0	0	0	0	0	0	0	0	0	(14,261)	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**	(14,261)	0	0	0	0	0	0	0	0	0	0	(14,261)	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	36,787	0	0	0	0	0	0	0	0	0	36,787	19
20	Fees, Subscriptions & Promotions	0	250	0	0	0	0	0	0	0	0	0	250	20
21	Clerical & General Office Expenses	0	132	0	0	0	0	0	0	0	0	0	132	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	33,827	0	0	0	0	0	0	0	0	0	33,827	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	70,996	0	0	0	0	0	0	0	0	0	70,996	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(14,261)	70,996	0	0	0	0	0	0	0	0	0	56,735	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number St Marys Square Living Ctr **#** 0034066 **Report Period Beginning:** 7/1/2012 **Ending:** 6/30/2013

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	213,912	0	0	0	0	0	0	0	0	0	213,912	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,211)	301,563	0	0	0	0	0	0	0	0	0	300,352	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(576,000)	0	0	0	0	0	0	0	0	0	(576,000)	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	(1,211)	(60,525)	0	0	0	0	0	0	0	0	0	(61,736)	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	(1,260)	0	0	0	0	0	0	0	0	0	0	(1,260)	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(680)	0	0	0	0	0	0	0	0	0	0	(680)	43
44	TOTAL Special Cost Centers	(1,940)	0	0	0	0	0	0	0	0	0	0	(1,940)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(17,412)	10,471	0	0	0	0	0	0	0	0	0	(6,941)	45

Facility Name & ID Number St Marys Square Living Ctr # 0034066 Report Period Beginning: 7/1/2012 Ending: 6/30/2013

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.	N/A			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	19	Professional Services		CRC Cherry Street Facility, LLC	0.00%	$ 36,787	$ 36,787	1
2	V	20	Licenses and Fees		CRC Cherry Street Facility, LLC	0.00%	250	250	2
3	V	21	General Administrative		CRC Cherry Street Facility, LLC	0.00%	132	132	3
4	V	26	Insurance-Prop.Liab.Malpractice		CRC Cherry Street Facility, LLC	0.00%	33,827	33,827	4
5	V	30	Depreciation		CRC Cherry Street Facility, LLC	0.00%	213,912	213,912	5
6	V	32	Interest	528	CRC Cherry Street Facility, LLC	0.00%	291,358	290,830	6
7	V	34	Rent-Facility & Grounds	576,000	CRC Cherry Street Facility, LLC	0.00%		(576,000)	7
8	V	32	Amortization of Loan costs		CRC Cherry Street Facility, LLC	0.00%	10,733	10,733	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 576,528			$ 586,999	$ * 10,471	14

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

Facility Name & ID Number St Marys Square Living Ctr # 0034066 Report Period Beginning: 7/1/2012 Ending: 6/30/2013

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
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28								28
29								29
30								30

Facility Name & ID Number St Marys Square Living Ctr # 0034066 Report Period Beginning: 7/1/2012 Ending: 6/30/2013

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	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Stanley Sydlowski, D.D.S.	President	Director	None	N/A	N/A	N/A	Board mtgs	$ 4,750	18-3	1
2	Charles D. Westbay	Secretary	Director	None	N/A	N/A	N/A	Board mtgs	4,750	18-3	2
3	Gary Bruington	Director	Director	None	N/A	N/A	N/A	Board mtgs	5,000	18-3	3
4	David Beversdorf	Director	Director	None	N/A	N/A	N/A	Board mtgs	5,000	18-3	4
5											5
6											6
7								Secretary fee	300	18-3	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 19,800		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 Marys Square Living Ctr # 0034066 Report Period Beginning: 7/1/2012 Ending: 6/30/2013

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 Marys Square Living Ctr # 0034066 Report Period Beginning: 7/1/2012 Ending: 6/30/2013

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Berkadia Commercial						$	$			$	1
2	Mortgage Corp		X	Facility Purchase	$39,717.00	9/1/2003	6,164,400	4,770,576	10/1/2028	6.0000	291,358	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$39,717.00		$ 6,164,400	$ 4,770,576			$ 291,358	9
	B. Non-Facility Related*											
10								Amortization of loan costs			10,733	10
11								Interest Income offset			(1,739)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 8,994	14
15	TOTALS (line 9+line14)						$ 6,164,400	$ 4,770,576			$ 300,352	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** 24,274 **Line #** 26

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

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

Facility Name & ID Number St Marys Square Living Ctr **#** 0034066 **Report Period Beginning:** 7/1/2012 **Ending:** 6/30/2013

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2012 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.)	**2012**	$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2013 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:			
	2008	N/A	8
	2009	N/A	9
	2010	N/A	10
	2011	N/A	11
	2012	N/A	12

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

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2012	$	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.

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME St Marys Square Living Ctr 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 2012 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 2012.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	N/A		$	$
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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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 Marys Square Living Ctr # 0034066 Report Period Beginning: 7/1/2012 Ending: 6/30/2013

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 Marys Square Living Ctr # 0034066 Report Period Beginning: 7/1/2012 Ending: 6/30/2013

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	$	30	$ 207,333	$ 207,333	$ 2,021,500	4
5			2003		131,518		20	6,579	6,579	63,025	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		29,380	10
11	Water chiller repair, boiler repair			1990	11,633		15-20 yrs			11,633	11
12	Roof repair, roofing			1991	49,477		20			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		30,232	15
16	A/C chiller, tuckpointing, roofing, transformer, elvator equip			1995	102,052	3,635	15-25 yrs	3,635		81,220	16
17	Alarm electric work, water heater, A.C. units, Stucco work			1996	59,408	864	10-25 yrs	864		52,208	17
18	A/C Units, fire alram system, paving			1997	62,969		8-15 yrs			62,969	18
19	Fire alarm, condesate ret. System			1998	10,166	227	10-15 yrs	227		10,090	19
20	Coils & stats, fire alarm, commercial door			1999	62,346	267	10-15 yrs	267		61,991	20
21	Kitchen upgrade, air conditioner rep, countertop, hall handle rep, HVAC			2000	30,547	1,444	10-15 yrs	1,444		27,857	21
22	Patio, Elevator renovation			2002	77,220	3,861	20	3,861		41,448	22
23	Air handler, Concrete construction, Vinyl flooring, patio constr.			2003	46,624	2,655	10-20 yrs	2,655		26,692	23
24	2004 Additions			2004	351,219	23,117	10-20 yrs	23,117		206,011	24
25	2005 Additions			2005	39,174	3,865	10	3,865		31,216	25
26	Sprinkler system			2006	25,839	1,723	15	1,723		12,202	26
27	Elevator, A/C, door closers, shower rm rpr, reclining air tub, water heater			2008	67,213	5,093	10-20 yrs	5,093		24,840	27
28	New valve on elevator			2009	12,644	632	20	632		2,792	28
29	Generator back-up freezer/refrigerator			2009	5,610	1,122	5	1,122		4,956	29
30	Electric work - elevator			2009	4,600	230	20	230		997	30
31	Elevator			2009	77,440	3,872	20	3,872		16,456	31
32	Circuit and well pump installation			2009	5,387	269	20	269		1,122	32
33	3rd floor shower remodel (drains/plumbing/showers/doors/tile)			2009	17,985	899	20	899		3,747	33
34	Tuck pointing and foundation repair			2009	18,800	940	20	940		3,838	34
35	Fire alarm			2009	3,293	329	10	329		1,344	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 Marys Square Living Ctr # 0034066 Report Period Beginning: 7/1/2012 Ending: 6/30/2013

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	$	$ 1,057	37
38	Rewire Elevator Controllers	2010	5,871	294	20	294		1,028	38
39	Water Heater	2010	5,698	570	10	570		1,852	39
40	Boiler Repairs	2010	4,394	439	10	439		1,354	40
41	Bathroom remodels - walls/floors/showers/toilets/cabinets/sink/cou	2010	137,256	11,438	12	11,438		35,267	41
42	Door Closers	2010	2,852	190	15	190		523	42
43	Tuck Pointing and caulking on exterior of building	2010	5,140	257	20	257		707	43
44	Bathroom remodel (walls/paint/plumbing/tile)	2010	67,590	5,633	12	5,633		14,552	44
45	Hydraulic Piston	2010	18,620	931	20	931		2,483	45
46	Bathroom #8 Remodel (walls/tile/shower stalls/drains/caulk)	2011	13,649	1,137	12	1,137		2,748	46
47	2 Boilers	2011	45,335	2,266	20	2,266		5,099	47
48	5 Door Closers	2012	3,153	315	10	315		368	48
49	5 Electric Door Closers	2012	3,237	216	10	216		216	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)		$ 7,919,183	$ 79,470		$ 293,382	$ 213,912	$ 2,995,470	70

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

Facility Name & ID Number St Marys Square Living Ctr # 0034066 Report Period Beginning: 7/1/2012 Ending: 6/30/2013

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	$ 529,007	$ 33,933	$ 33,933	$	5-20yrs	$ 390,245	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 529,007	$ 33,933	$ 33,933	$		$ 390,245	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	$ 1,450	$ 1,450	$	4 yrs	$ 240,125	76
77										77
78										78
79										79
80	TOTALS			$ 240,125	$ 1,450	$ 1,450	$		$ 240,125	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)	$ 8,872,315	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 114,853	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 328,765	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 213,912	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,625,840	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 Marys Square Living Ctr # 0034066 Report Period Beginning: 7/1/2012 Ending: 6/30/2013

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A Facility Owned
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.	/2014	$
13.	/2015	$
14.	/2016	$

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
    (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	N/A				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 Marys Square Living Ctr # 0034066 Report Period Beginning: 7/1/2012 Ending: 6/30/2013

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)		120,187		120,187
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$ 120,187	$	$ 120,187
10	SUM OF line 9, col. 1 and 2 (e)	$ 120,187			

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	61
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	61

(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 Marys Square Living Ctr # 0034066 Report Period Beginning: 7/1/2012 Ending: 6/30/2013

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	N/A	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 Marys Square Living Ctr # 0034066 Report Period Beginning: 7/1/2012 Ending: 6/30/2013

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/2013 (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	$ 407,351	$ 446,054	1
2	Cash-Patient Deposits	66,686	66,686	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 20,000)	2,634,718	2,634,718	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	50,341	57,091	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule II	39,687	29,216	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,198,783	$ 3,233,765	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	1,567,665	7,919,183	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	769,132	769,132	16
17	Accumulated Depreciation (book methods)	(1,541,315)	(3,625,840)	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):	90,916	90,916	22
23	Other(specify): See Attached Schedule II		1,042,852	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 896,398	$ 6,390,243	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,095,181	$ 9,624,008	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 78,229	$ 78,229	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	66,686	66,686	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	379,455	379,455	30
31	Accrued Taxes Payable (excluding real estate taxes)	7,046	7,046	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable		23,853	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Management Fees	18,176	18,176	36
37	Health Insurance Assessment	62,831	62,831	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 612,423	$ 636,276	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,770,576	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Due to Frances House	1,325,000	1,325,000	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,325,000	$ 6,095,576	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,937,423	$ 6,731,852	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,157,758	$ 2,892,156	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,095,181	$ 9,624,008	48

*(See instructions.)

Facility Name & ID Number St Marys Square Living Ctr # 0034066 Report Period Beginning: 7/1/2012 Ending: 6/30/2013

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,019,177	1
2	Restatements (describe):		2
3	Rounding	1	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,019,178	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	128,109	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) CRC Cherry St. net income transfer	10,471	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 138,580	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)**	$ 2,157,758	24 *

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

Facility Name & ID Number St Marys Square Living Ctr # 0034066 Report Period Beginning: 7/1/2012 Ending: 6/30/2013

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	$ 9,767,597	1
2	Discounts and Allowances for all Levels		2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 9,767,597	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	120,187	11
12	Gift and Coffee Shop	18,671	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)**	$ 138,858	23
	D. Non-Operating Revenue		
24	Contributions	25,070	24
25	Interest and Other Investment Income***	1,211	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 26,281	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,932,736	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,995,848	31
32	Health Care	4,333,656	32
33	General Administration	2,214,918	33
	B. Capital Expense		
34	Ownership	690,853	34
	C. Ancillary Expense		
35	Special Cost Centers	1,940	35
36	Provider Participation Fee	567,412	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,804,627	40
41	**Income before Income Taxes (line 30 minus line 40)****	128,109	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 128,109	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 8,283,503	44
45	Private Pay - Net Inpatient Revenue	1,484,094	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)	$ 9,767,597	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 Marys Square Living Ctr # 0034066 Report Period Beginning: 7/1/2012 Ending: 6/30/2013

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	1,440	1,840	$ 43,733	$ 23.77	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,458	3,804	87,852	23.09	3
4	Licensed Practical Nurses	43,954	50,718	783,939	15.46	4
5	CNAs & Orderlies	225,210	246,626	2,401,853	9.74	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	5,626	6,281	79,510	12.66	9
10	Activity Assistants					10
11	Social Service Workers	6,338	7,002	77,694	11.10	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	35,202	39,344	392,441	9.97	15
16	Dishwashers					16
17	Maintenance Workers	9,653	10,367	165,654	15.98	17
18	Housekeepers	26,986	30,024	302,448	10.07	18
19	Laundry	16,441	17,916	178,952	9.99	19
20	Administrator	2,064	2,080	98,272	47.25	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	14,621	15,746	175,243	11.13	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	33,589	36,579	530,821	14.51	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,992	2,080	17,568	8.45	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	426,574	470,407	$ 5,335,980 *	$ 11.34	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	Monthly	$ 6,623	L1, C3	35
36	Medical Director	Monthly	21,650	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	11,262	L10, C3	39
40	Physical Therapy Consultant	Monthly	2,363	L10A, C3	40
41	Occupational Therapy Consultant	Monthly	2,325	L10A, C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	Monthly	2,587	L10A, C3	43
44	Activity Consultant				44
45	Social Service Consultant	Monthly	506	L12, C3	45
46	Other(specify) Dental	Monthly	7,025	L10, C3	46
47	Psychological Consultant	Monthly	15,577	L10, C3	47
48					48
49	TOTAL (lines 35 - 48)		$ 69,918		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	N/A	$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number St Marys Square Living Ctr # 0034066 Report Period Beginning: 7/1/2012 Ending: 6/30/2013

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Bobby Dillard	Administrator	None	$ 98,272
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 98,272

B. Administrative - Other

Description	Amount
N/A	$
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	$ 260,113
LTC Support Services, LLC	Support Services	87,240
McGladrey LLP	Accounting Services	150,660
Margel Petticord	Accounting Services	940
MPRO	Peer Review	5,770
Crain, Miller & Wernsman, LTD	Legal Services	6,796
Davis & Campbell, LLC	Legal Services	312
Duane Morris LLP	Legal Services	2,731
Polsinelli Shugart PC	Legal Services	15,048
Legat Architects	Architectect Services	2,500
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 532,110

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 230,471
Unemployment Compensation Insurance	2,542
FICA Taxes	402,244
Employee Health Insurance	530,970
Employee Meals	11,300
Illinois Municipal Retirement Fund (IMRF)*	
401k	36,156
Other Employee Benefits	11,882
Employee Appreciation	
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,225,565

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

Description	Line #	Amount
N/A		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	19,705
Health Care Worker Background Check	
(Indicate # of checks performed 136)	4,376
Patient Background Checks 2	
Subscriptions	8,069
Other Licenses & Fees	225
Indirect costs	250
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 32,625

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,336
See Attached Schedule III	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,336

**See instructions.

Facility Name & ID Number St Marys Square Living Ctr # 0034066 Report Period Beginning: 7/1/2012 Ending: 6/30/2013

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	N/A												
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number St Marys Square Living Ctr # 0034066 Report Period Beginning: 7/1/2012 Ending: 6/30/2013

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? **N/A**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **59,455** 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.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **567,412**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **11,300** 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? **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 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.

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustments	Adjusted Total
1. Dietary	392,441	31,259	6,623	430,323	0	430,323	0	430,323
2. Food Purchase	0	432,453	0	432,453	0	432,453	-14,261	418,192
3. Housekeeping	302,448	45,519	0	347,967	0	347,967	0	347,967
4. Laundry	178,952	39,994	14	218,960	0	218,960	0	218,960
5. Heat and Other Utilities	0	0	273,388	273,388	0	273,388	0	273,388
6. Maintenance	165,654	33,442	93,661	292,757	0	292,757	0	292,757
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	1,039,495	582,667	373,686	1,995,848	0	1,995,848	-14,261	1,981,587
9. Medical Director	0	0	21,650	21,650	0	21,650	0	21,650
10. Nursing & Medical Records	3,745,579	207,398	33,864	3,986,841	0	3,986,841	0	3,986,841
10a. Therapy	0	0	7,275	7,275	0	7,275	0	7,275
11. Activities	79,510	7,739	15,509	102,758	0	102,758	0	102,758
12. Social Services	77,694	0	506	78,200	0	78,200	0	78,200
13. Nurse Aide Training	120,187	0	0	120,187	0	120,187	0	120,187
14. Program Transportation	0	0	16,745	16,745	0	16,745	0	16,745
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	4,022,970	215,137	95,549	4,333,656	0	4,333,656	0	4,333,656
17. Administrative	98,272	0	0	98,272	0	98,272	0	98,272
18. Directors Fees	0	0	19,800	19,800	0	19,800	0	19,800
19. Professional Services	0	0	532,110	532,110	0	532,110	36,787	568,897
20. Fees, Subscriptions & Promotion	0	0	32,375	32,375	0	32,375	250	32,625
21. Clerical & General Office	175,243	46,907	14,135	236,285	0	236,285	132	236,417
22. Employee Benefits & Payroll	0	0	1,225,565	1,225,565	0	1,225,565	0	1,225,565
23. Inservice Training & Education	0	0	1,177	1,177	0	1,177	0	1,177
24. Travel and Seminar	0	0	2,336	2,336	0	2,336	0	2,336
25. Other Admin. Staff Trans	0	0	7,136	7,136	0	7,136	0	7,136
26. Insurance-Prop.Liab.Malpractice	0	0	59,862	59,862	0	59,862	33,827	93,689
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	273,515	46,907	1,894,496	2,214,918	0	2,214,918	70,996	2,285,914
29. Total General Administrative	5,335,980	844,711	2,363,731	8,544,422	0	8,544,422	56,735	8,601,157
30. Depreciation	0	0	114,853	114,853	0	114,853	213,912	328,765
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	0	0	0	0	300,352	300,352
33. Real Estate	0	0	0	0	0	0	0	0

34.	Rent - Facility & Grounds		0	0	576,000	576,000	0	576,000	-576,000	0
35.	Rent - Equipment & Vehicles		0	0	0	0	0	0	0	0
36.	Other (specify):*		0	0	0	0	0	0	0	0
37.	Total Ownership		0	0	690,853	690,853	0	690,853	-61,736	629,117
38.	Medically Necessary T		0	0	0	0	0	0	0	0
39.	Ancillary Service Cent		0	0	0	0	0	0	0	0
40.	Barber and Beauty Shop		0	0	0	0	0	0	0	0
41.	Coffee and Gift Shops		0	1,260	0	1,260	0	1,260	-1,260	0
		42	0	0	567,412	567,412	0	567,412	0	567,412
43.	Other (specify):*		0	0	680	680	0	680	-680	0
44.	Total Special Cost Ce		0	1,260	568,092	569,352	0	569,352	-1,940	567,412
45.	Grand Total		5,335,980	845,971	3,622,676	9,804,627	0	9,804,627	-6,941	9,797,686

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	407,351	446,054
2. Cash - Patient Deposits	66,686	66,686
3. Accounts & Notes Recievable	2,634,718	2,634,718
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	50,341	57,091
7. Other Prepaid Expenses	0	0
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	39,687	29,216
10. Total current assets	3,198,783	3,233,765
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	10,000	10,000
13. Land	0	184,000
14. Buildings, at Historical Cost	1,567,665	7,919,183
15. Leasehold Improvements, Historical Cost	0	0
16. Equipment, at Historical Cost	769,132	769,132
17. Accumulated Depreciation (book methods)	-1,541,315	-3,625,840
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	90,916	90,916
23. other (specify):	0	1,042,852
24. Total Long-Term Assets	896,398	6,390,243
25. Total Assets	4,095,181	9,624,008
CURRENT LIABILITIES		
26. Accounts Payable	78,229	78,229
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	66,686	66,686
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	379,455	379,455
31. Accrued Taxes Payable	7,046	7,046
32. Accrued Real Estate Taxes	0	0
33. Accrued Interest Payable	0	23,853
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	18,176	18,176

37. Other Current Liabilities (specify):	62,831	62,831
38. Total Current Liabilities	612,423	636,276
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	0
40.Mortgage Payable	0	4,770,576
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	1,325,000	1,325,000
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	1,325,000	6,095,576
46.Total Liabilities	1,937,423	6,731,852
47.Total Equity	2,157,758	2,892,156
48.Total Liabilities and Equity	4,095,181	9,624,008

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	9,767,597
2. Discounts and Allowances for all Levels	0
Subtotal - Inpatient Care	9,767,597
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	0
7. Oxygen	0
Subtotal - Anciliary Revenue	-
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	120,187
12. Gift and Coffee Shop	18,671
13. Barber and Beauty Care	0
14. Non-Patient Meals	0
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	0
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiologyand X-Ray	0
21. Other Medical Services	0
22. Laundry	0
Subtotal - Other Operating Revenue	138,858
24. Contributions	25,070
25. Interest and Other Investments Income	1,211
Subtotal - Non-Operating Revenue	26,281
27. Other Revenue (specify):	0
28. Other Revenue (specify):	0
Subtotal - Other Revenue	-
30. Total Revenue	9,932,736
31. General Services	1,995,848
32. Health Care	4,333,656
33. General Administration	2,214,918
34. Ownership	690,853

35.	Special Cost Centers	1,940
35.	Provider Participation Fee	567,412
37.	Other	0
40.	Total Expenses	9,804,627
41.	Income Before Income Taxes	128,109
42.	Income Taxes	0
43.	Net Income or Loss for the Year	128,109