



Facility Name & ID Number PROVENA ST ANNE CENTER

# 0041731 Report Period Beginning: 01/01/01 Ending: 12/31/01

**III. STATISTICAL DATA**

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	120	Skilled (SNF)	120	43,800	1
2		Skilled Pediatric (SNF/PED)			2
3	59	Intermediate (ICF)	59	21,535	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	179	TOTALS	179	65,335	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF		1,291	8,078	9,369	8
9	SNF/PED					9
10	ICF	33,741	20,716		54,457	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	33,741	22,007	8,078	63,826	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.69%

D. How many bed-hold days during this year were paid by Public Aid? NONE (Do not include bed-hold days in Section B.)

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

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

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

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

I. On what date did you start providing long term care at this location?  
Date started 10/06/1986

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date \_\_\_\_\_ NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 59 and days of care provided 8078

Medicare Intermediary ADMINASTAR FEDERAL, INC.

**IV. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/01 Fiscal Year: 12/31/01

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

Facility Name & ID Number PROVENA ST ANNE CENTER # 0041731 Report Period Beginning: 01/01/01 Ending: 12/31/01

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	348,542	45,962	14,343	408,847		408,847		408,847		1
2	Food Purchase		340,514		340,514		340,514		340,514		2
3	Housekeeping	200,779	25,359	4,298	230,436		230,436	2,037	232,473		3
4	Laundry	29,950	9,084	121,226	160,260		160,260		160,260		4
5	Heat and Other Utilities			157,357	157,357		157,357	(10,996)	146,361		5
6	Maintenance	72,187	27,203	52,471	151,861		151,861	719	152,580		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	651,458	448,122	349,695	1,449,275		1,449,275	(8,240)	1,441,035		8
	<b>B. Health Care and Programs</b>										
9	Medical Director	93,896		16,670	110,566		110,566		110,566		9
10	Nursing and Medical Records	2,623,427	273,121	168,742	3,065,290		3,065,290	13,670	3,078,960		10
10a	Therapy	90,168			90,168		90,168		90,168		10a
11	Activities	92,919	10,204	3,141	106,264		106,264		106,264		11
12	Social Services	131,363	1,116	9,605	142,084		142,084	6,233	148,317		12
13	Nurse Aide Training										13
14	Program Transportation			367	367		367		367		14
15	Other (specify):*							5,268	5,268		15
16	<b>TOTAL Health Care and Programs</b>	3,031,773	284,441	198,525	3,514,739		3,514,739	25,171	3,539,910		16
	<b>C. General Administration</b>										
17	Administrative	135,616		584,500	720,116		720,116	(514,827)	205,289		17
18	Directors Fees										18
19	Professional Services			83,462	83,462		83,462	23,800	107,262		19
20	Dues, Fees, Subscriptions & Promotions			37,772	37,772		37,772	(11,680)	26,092		20
21	Clerical & General Office Expenses	147,259	35,683	274,933	457,875		457,875	(72,755)	385,120		21
22	Employee Benefits & Payroll Taxes			774,715	774,715		774,715	(4,675)	770,040		22
23	Inservice Training & Education							19,974	19,974		23
24	Travel and Seminar			18,955	18,955		18,955	(5,861)	13,094		24
25	Other Admin. Staff Transportation			3,471	3,471		3,471	4,704	8,175		25
26	Insurance-Prop.Liab.Malpractice			23,880	23,880		23,880	1,371	25,251		26
27	Other (specify):*							43,497	43,497		27
28	<b>TOTAL General Administration</b>	282,875	35,683	1,801,688	2,120,246		2,120,246	(516,452)	1,603,794		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	3,966,106	768,246	2,349,908	7,084,260		7,084,260	(499,521)	6,584,739		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 PROVENA ST ANNE CENTER

#0041731

Report Period Beginning:

01/01/01

Ending:

12/31/01

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			374,847	374,847		374,847	516	375,363			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							226,513	226,513			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds							15,768	15,768			34
35	Rent-Equipment & Vehicles			605	605		605		605			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			375,452	375,452		375,452	242,797	618,249			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		817,841	429,208	1,247,049		1,247,049		1,247,049			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			98,001	98,001		98,001		98,001			42
43	Other (specify):*	35,475	2,256	10,983	48,714		48,714	(48,714)				43
44	<b>TOTAL Special Cost Centers</b>	35,475	820,097	538,192	1,393,764		1,393,764	(48,714)	1,345,050			44
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	4,001,581	1,588,343	3,263,552	8,853,476		8,853,476	(305,439)	8,548,037			45

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

**VI. ADJUSTMENT DETAIL**

**A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.**

**In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

		1	2	3	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>OHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(12,036)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	516	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(314)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(187,688)	21		24
25	Fund Raising, Advertising and Promotional	(13,534)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(68,417)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (281,474)		\$	30

<b>OHF USE ONLY</b>					
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	2	
		<b>Amount</b>	<b>Reference</b>	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(23,965)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (23,965)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ (305,439)		37

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

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

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

NON-ALLOWABLE EXPENSES	Amount	Sch. V Line	Reference
1 PRIOR YEAR LEGAL	\$ (29)	19	1
2 EXECUTIVE BENEFITS	(6,674)	32	2
3 NONALLOWABLE DEVELOPMENT EXPENSES	(48,714)	43	3
4 MISCELLANEOUS INCOME	(870)	21	4
5 OTHER NON-OP INCOME	(504)	21	5
6 MAINTENANCE CONTRACT INCOME	(927)	06	6
7 NON-ALLOWABLE SEMINAR EXPENSE	(12,698)	24	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
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82			82
83			83
84			84
85			85
86			86
87			87
88			88
89			89
90			90
91			91

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number PROVENA ST ANNE CENTER# 0041731

Report Period Beginning:

01/01/01

Ending:

12/31/01

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary													1
2	Food Purchase													2
3	Housekeeping			2,037									2,037	3
4	Laundry													4
5	Heat and Other Utilities	(12,036)		1,040									(10,996)	5
6	Maintenance	(927)		1,646									719	6
7	Other (specify):*													7
8	<b>TOTAL General Services</b>	<b>(12,963)</b>		<b>4,723</b>									<b>(8,240)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records			13,670									13,670	10
10a	Therapy													10a
11	Activities													11
12	Social Services			6,233									6,233	12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*			5,268									5,268	15
16	<b>TOTAL Health Care and Programs</b>			<b>25,171</b>									<b>25,171</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative			(514,827)									(514,827)	17
18	Directors Fees													18
19	Professional Services	(29)		23,829									23,800	19
20	Fees, Subscriptions & Promotions	(13,848)		2,168									(11,680)	20
21	Clerical & General Office Expenses	(189,062)		116,307									(72,755)	21
22	Employee Benefits & Payroll Taxes	(4,675)											(4,675)	22
23	Inservice Training & Education			19,974									19,974	23
24	Travel and Seminar	(12,698)		6,837									(5,861)	24
25	Other Admin. Staff Transportation			4,704									4,704	25
26	Insurance-Prop.Liab.Malpractice			1,371									1,371	26
27	Other (specify):*			43,497									43,497	27
28	<b>TOTAL General Administration</b>	<b>(220,312)</b>		<b>(296,140)</b>									<b>(516,452)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(233,275)</b>		<b>(266,246)</b>									<b>(499,521)</b>	<b>29</b>

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number PROVENA ST ANNE CENTER# 0041731

Report Period Beginning:

01/01/01

Ending:

12/31/01

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
30	Depreciation	516											516	30
31	Amortization of Pre-Op. & Org.													31
32	Interest			226,513									226,513	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds			15,768									15,768	34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*													36
37	<b>TOTAL Ownership</b>	516		242,281									242,797	37
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(48,714)											(48,714)	43
44	<b>TOTAL Special Cost Centers</b>	(48,714)											(48,714)	44
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	(281,474)		(23,965)									(305,439)	45

**VII. RELATED PARTIES**

**A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
PROVENA SENIOR SERVICES	100%	SEE ATTACHED		SEE ATTACHED		
PROVENA HEALTH	100%					

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

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

**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	3 HOUSEKEEPING	\$	PROVENA SENIOR SERVICES	100.00%	\$ 2,037	\$	2,037	15
16	V	5 UTILITIES		PROVENA SENIOR SERVICES	100.00%	1,040		1,040	16
17	V	6 REPAIRS AND MAINT.		PROVENA SENIOR SERVICES	100.00%	1,646		1,646	17
18	V	10 NURSING		PROVENA SENIOR SERVICES	100.00%	13,670		13,670	18
19	V	12 SOCIAL SERVICES		PROVENA SENIOR SERVICES	100.00%	6,233		6,233	19
20	V	15 EMPLOYEE BENEFITS		PROVENA SENIOR SERVICES	100.00%	5,268		5,268	20
21	V	17 ADMINISTRATIVE	584,500	PROVENA SENIOR SERVICES	100.00%	69,673		(514,827)	21
22	V	19 PROFESSIONAL FEES		PROVENA SENIOR SERVICES	100.00%	23,829		23,829	22
23	V	20 DUES,SUBSCRIPTIONS		PROVENA SENIOR SERVICES	100.00%	2,168		2,168	23
24	V	21 CLERICAL		PROVENA SENIOR SERVICES	100.00%	116,307		116,307	24
25	V	23 INSERVICE TRAINING		PROVENA SENIOR SERVICES	100.00%	19,974		19,974	25
26	V	24 SEMINARS		PROVENA SENIOR SERVICES	100.00%	6,837		6,837	26
27	V	25 ADMIN. STAFF TRAVEL		PROVENA SENIOR SERVICES	100.00%	4,704		4,704	27
28	V	26 INSURANCE		PROVENA SENIOR SERVICES	100.00%	1,371		1,371	28
29	V	27 EMPLOYEE BENEFITS		PROVENA SENIOR SERVICES	100.00%	43,497		43,497	29
30	V	32 INTEREST-DIRECT ALLOCATION		PROVENA SENIOR SERVICES	100.00%	226,513		226,513	30
31	V	34 RENT		PROVENA SENIOR SERVICES	100.00%	15,768		15,768	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 584,500			\$ 560,535	\$ *	(23,965)	39

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

**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	10 PHARMACY-STOCK ITEMS	\$ 13,993	PROVENA SENIOR SERVICES PHARMACY	100.00%	\$ 13,993	\$
16	V	39 PHARMACY	789,979	PROVENA SENIOR SERVICES PHARMACY	100.00%	789,979	
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	<b>Total</b>		\$ 803,972			\$ 803,972	\$ *

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

**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	19 COMPUTER	\$ 74,004	PROVENA HEALTH	100.00%	\$ 74,004	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	<b>Total</b>		\$ 74,004			\$ 74,004	\$ *	39

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

**VII. RELATED PARTIES (continued)**

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	<b>Total</b>			\$			\$	\$ *	39

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

**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	<b>Total</b>		\$			\$	\$ *	39

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

**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	<b>Total</b>		\$			\$	\$ *	39

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

**VII. RELATED PARTIES (continued)**

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	<b>Total</b>			\$			\$	\$ *	39

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

**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	<b>Total</b>		\$			\$	\$ *	39

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

**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	<b>Total</b>		\$			\$	\$ *	39

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

Facility Name &amp; ID Number

PROVENA ST ANNE CENTER

# 0041731

Report Period Beginning:

01/01/01

Ending:

12/31/01

## VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		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 PROVENA ST ANNE CENTER

# 0041731

Report Period Beginning:

01/01/01

Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization \_\_\_\_\_

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

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number PROVENA ST ANNE CENTER

# 0041731

Report Period Beginning:

01/01/01

Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization PROVENA SENIOR SERVICES  
 Street Address 200 E COURT STREET SUITE 200  
 City / State / Zip Code KANKAKEE, IL 60901  
 Phone Number ( 815 ) 928-6851  
 Fax Number ( 815 ) 928-6160

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	MGT FEE INCOME	5,221,293	17	\$ 18,200	\$ 584,500	\$ 2,037	1
2	5	UTILITIES	MGT FEE INCOME	5,221,293	17	9,294	584,500	1,040	2
3	6	REPAIRS AND MAINT.	MGT FEE INCOME	5,221,293	17	14,705	584,500	1,646	3
4	10	NURSING	MGT FEE INCOME	5,221,293	17	122,116	584,500	13,670	4
5	12	SOCIAL SERVICES	MGT FEE INCOME	5,221,293	17	55,680	584,500	6,233	5
6	15	EMPLOYEE BENEFITS	MGT FEE INCOME	5,221,293	17	47,063	584,500	5,268	6
7	17	ADMINISTRATIVE	MGT FEE INCOME	5,221,293	17	622,384	584,500	69,673	7
8	19	PROFESSIONAL FEES	MGT FEE INCOME	5,221,293	17	212,867	584,500	23,829	8
9	20	DUES,SUBSCRIPTIONS	MGT FEE INCOME	5,221,293	17	19,371	584,500	2,168	9
10	21	CLERICAL	MGT FEE INCOME	5,221,293	17	1,038,965	584,500	116,307	10
11	23	INSERVICE TRAINING	MGT FEE INCOME	5,221,293	17	178,422	584,500	19,974	11
12	24	SEMINARS	MGT FEE INCOME	5,221,293	17	61,070	584,500	6,837	12
13	25	ADMIN. STAFF TRAVEL	MGT FEE INCOME	5,221,293	17	42,016	584,500	4,704	13
14	26	INSURANCE	MGT FEE INCOME	5,221,293	17	12,250	584,500	1,371	14
15	27	EMPLOYEE BENEFITS	MGT FEE INCOME	5,221,293	17	388,552	584,500	43,497	15
16	32	INTEREST-DIRECT ALLOCAT	DIRECT ALLOCATION			2,258,265		226,513	16
17	34	RENT	MGT FEE INCOME	5,221,293	17	140,857	584,500	15,768	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 5,242,077	\$ 1,758,540	\$ 560,535	25

Facility Name & ID Number PROVENA ST ANNE CENTER

# 0041731

Report Period Beginning:

01/01/01

Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization PROVENA SENIOR SERVICES PHARMACY  
 Street Address 1475 HARVARD DRIVE  
 City / State / Zip Code KANKAKEE, IL 60901  
 Phone Number ( 815)928-6141  
 Fax Number ( 815)946-3238

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	10	PHARMACY-STOCK ITEMS	DIRECT ALLOCATION					13,993	1
2	39	PHARMACY	DIRECT ALLOCATION					789,979	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				\$	\$		\$ 803,972	25

Facility Name & ID Number PROVENA ST ANNE CENTER

# 0041731

Report Period Beginning:

01/01/01

Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization PROVENA HEALTH  
 Street Address 9223 WEST ST. FRANCIS ROAD  
 City / State / Zip Code FRANKFURT, IL 60423  
 Phone Number ( 815)469-4888  
 Fax Number ( 815)469-4864

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	19	COMPUTER	DIRECT ALLOCATION					74,004	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				\$	\$		\$ 74,004	25

Facility Name & ID Number PROVENA ST ANNE CENTER

# 0041731

Report Period Beginning: 01/01/01

Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization \_\_\_\_\_

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

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number PROVENA ST ANNE CENTER

# 0041731

Report Period Beginning: 01/01/01

Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization \_\_\_\_\_

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

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number PROVENA ST ANNE CENTER

# 0041731

Report Period Beginning: 01/01/01

Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number PROVENA ST ANNE CENTER

# 0041731

Report Period Beginning:

01/01/01

Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization \_\_\_\_\_

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

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number PROVENA ST ANNE CENTER

# 0041731

Report Period Beginning:

01/01/01

Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization \_\_\_\_\_

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

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number PROVENA ST ANNE CENTER

# 0041731

Report Period Beginning: 01/01/01

Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization \_\_\_\_\_

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

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number **PROVENA ST ANNE CENTER**

# **0041731**

Report Period Beginning:

**01/01/01**

Ending:

**12/31/01**

**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	Name of Lender	2		3	4	5	6		7	8	9	10					
		Related**					Monthly Payment Required	Date of Note					Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
<b>A. Directly Facility Related</b>																	
<b>Long-Term</b>																	
1							\$	\$			\$	1					
2												2					
3												3					
4												4					
5												5					
<b>Working Capital</b>																	
6												6					
7												7					
8												8					
9	<b>TOTAL Facility Related</b>						\$	\$			\$	9					
<b>B. Non-Facility Related*</b>																	
10	<b>See Supplemental Schedule</b>											10					
11	<b>ALLOC-PROVENA SENIOR</b>	<b>X</b>										<b>226,513</b>					
12												12					
13												13					
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	<b>226,513</b>					
15	<b>TOTALS (line 9+line14)</b>						\$	\$			\$	<b>226,513</b>					

\* 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

PROVENA ST ANNE CENTER

# 0041731

Report Period Beginning:

01/01/01

Ending:

12/31/01

**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	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
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					

Facility Name & ID Number **PROVENA ST ANNE CENTER**

# **0041731**

Report Period Beginning:

**01/01/01**

Ending:

**12/31/01**

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

**B. Real Estate Taxes**

**Important**, please see the next worksheet, "RE\_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2000 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 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	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:	1996	8	
	1997	9	
	1998	10	
	1999	11	
	2000	12	
			<b>FOR OHF USE ONLY</b>
	13	FROM R. E. TAX STATEMENT FOR 2000 \$	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.**

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Office of Health Finance at (217) 782-1630.

**2000 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME PROVENA ST ANNE CENTER COUNTY WINNEBAGO

FACILITY IDPH LICENSE NUMBER 0041731

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

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

Enter the tax index number and real estate tax assessed for 2000 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 2000.

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

**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 & 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 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number PROVENA ST ANNE CENTER

# 0041731

Report Period Beginning:

01/01/01 Ending:

12/31/01

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 70,000 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 1

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

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

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

NONE

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

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

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

**XI. OWNERSHIP COSTS:**

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>FACILITY</u>		<u>1985</u>	\$ <u>645,354</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>			\$ <b>645,354</b>	<b>3</b>

**XI. OWNERSHIP COSTS (continued)**

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	179			1993	\$ 2,722,251	\$ 90,742	35	\$ 90,742	\$ (0)	\$ 762,996	4
5				1986	3,516,907	100,483	35	100,483	0	1,635,866	5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	Various			1987	11,149		20	127	127	1,777	9
10	Various			1988	36,602		20	-		-	10
11	Various			1989	17,258		20	-		-	11
12	Various			1990	49,365		20	1,122	(1,122)	14,407	12
13	Various			1991	30,413		20	1,860	1,860	30,799	13
14	Various			1992	14,777		20	1,028	1,028	9,763	14
15	Various			1993	5,073		20	813	813	6,909	15
16	Various			1994	13,752		20	703	703	5,274	16
17	Various			1995	50,737		20	2,376	2,376	15,255	17
18	Various			1996	50,269		20	2,610	2,610	14,839	18
19	Various			1997	56,965		20	13,681	13,681	56,646	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

\*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 PROVENA ST ANNE CENTER

# 0041731

Report Period Beginning:

01/01/01

Ending:

12/31/01

**XI. OWNERSHIP COSTS (continued)**

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$ -	\$	\$ -	37
38					-		-	38
39					-		-	39
40					-		-	40
41					-		-	41
42					-		-	42
43					-		-	43
44					-		-	44
45					-		-	45
46					-		-	46
47					-		-	47
48					-		-	48
49					-		-	49
50					-		-	50
51					-		-	51
52					-		-	52
53					-		-	53
54					-		-	54
55					-		-	55
56					-		-	56
57					-		-	57
58					-		-	58
59					-		-	59
60					-		-	60
61					-		-	61
62					-		-	62
63					-		-	63
64					-		-	64
65					-		-	65
66					-		-	66
67					-		-	67
68			-		-		-	68
69					67,490		(67,490)	69
70		\$ 6,575,517	\$ 258,715		\$ 215,545	\$ (45,414)	\$ 2,554,530	70

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

Facility Name & ID Number PROVENA ST ANNE CENTER# 0041731

Report Period Beginning:

01/01/01

Ending:

12/31/01**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 6,575,517	\$ 258,715		\$ 215,545	\$ (43,170)	\$ 2,554,530	1
2	REPAIR LEAK MAIN OFFICE	1998	577		20	115	115	404	2
3	DOOR HOLDER CLOSER & ALARM DOO	1998	630		20	126	126	441	3
4	FIRE ALARM SYSTEM REPAIRS	1998	566		20	113	113	396	4
5	REGLAZING OF 2 PCC	1998	325		20	65	65	228	5
6	REPLACEMENT OF 1 PCC SASH	1998	274		20	55	55	192	6
7	NORTON DOOR CLOSER/HOLDER	1998	818		20	164	164	572	7
8	KITCHEN ICE MACHINE	1998	660		20	132	132	462	8
9	TRANSFORMER,CIRCUIT BREAKER, TI	1998	677		20	135	135	474	9
10	HEADRAILS (2)	1998	354		20	71	71	248	10
11	HOT WATER SUPPLY-WEST BASEMENT	1998	475		20	95	95	333	11
12	COLD WATER SUPPLY VALVE	1998	560		20	112	112	392	12
13	TEMPERATURE GAUGE/MIXER VALVE	1998	230		20	46	46	161	13
14	INSTALLATION (4) OL13C CIRCUIT	1998	1,208		20	242	242	846	14
15	WATER MIXER VALVE/NORTH WING	1998	267		20	53	53	187	15
16	WALK-IN REFRIGERATOR LIGHTS	1998	340		20	68	68	238	16
17	HVAC/DINING ROOM	1998	731		20	146	146	512	17
18	CONVEYOR WAREWASHERS	1998	207		20	41	41	145	18
19	CONVEYOR WAREWASHERS	1998	359		20	72	72	251	19
20	CORDLESS TELEPHONE ANTENNA'S (	1998	280		20	56	56	196	20
21	ICE MACHINE REPRS (WEST DINING	1998	781		20	156	156	547	21
22	15 SECOND DELAY ALARM (OUTSIDE	1998	639		20	128	128	447	22
23	HVAC CONTACTOR,CONTACT,THERMOS	1998	715		20	143	143	501	23
24	AIR CONDITIONER REPAIRS	1998	636		20	127	127	445	24
25	AIR HANDLER FILTER FRAME & PAD	1998	559		20	112	112	391	25
26	INSTALL OMNICELL UNITS	1998	1,276		20	255	255	893	26
27	PUSHBUTTON LATCHLOCK	1998	325		20	81	81	284	27
28	OMNICELL	1998	1,183		20	237	237	828	28
29	YALE KNOB LOCKS & KEYS	1998	480		20	96	96	336	29
30	RELOCATE POWER FEED CIRCUITS	1998	621		20	124	124	435	30
31	COMPRESSOR	1998	630		20	126	126	441	31
32	BATHROOM TOILET (RM F50)	1998	538		20	108	108	377	32
33	MAKE-UP AIR UNIT REPAIRS/KITCH	1998	669		20	134	134	468	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 6,594,105	\$ 258,715		\$ 219,279	\$ (39,436)	\$ 2,567,598	34

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

Facility Name & ID Number PROVENA ST ANNE CENTER# 0041731

Report Period Beginning:

01/01/01

Ending:

12/31/01**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12B, Carried Forward</b>		\$ 6,594,105	\$ 258,715		\$ 219,279	\$ (39,436)	\$ 2,567,598	1
2	REPAIR KITS/WALL HYDRANTS (2)	1998	1,012		20	202	202	708	2
3	POWER LINE/FOOD WARMER & PLATE	1998	603		20	121	121	422	3
4	EDWARDS FIRE ALARM SYSTEM REPA	1998	639		20	128	128	447	4
5	ICE MACHINE REPAIRS (KITCHEN &	1998	607		20	121	121	425	5
6	HEAT/COOL UNIT REPAIRS	1998	658		20	132	132	461	6
7	REPLACE GFI RECEPTACLES (KITCH	1998	905		20	181	181	633	7
8	INDUCER MOTOR & BLOWER WHEEL (	1998	615		20	123	123	430	8
9	FIRE ALARMS	1998	660		20	132	132	462	9
10	WANDER GUARD MOTION DETECTOR	1998	1,019		20	204	204	713	10
11	INTERIOR PAINTING/WALLPAPER	1998	875		20	175	175	613	11
12	DISHWASHER DRAIN LINE REPAIR	1998	2,135		20	427	427	1,494	12
13	VENTOR MOTOR ASSEMBLY	1998	725		20	145	145	508	13
14	HALLWAY DRYWALL REPAIRS	1998	548		20	110	110	384	14
15	EQUIPMENT ROOM AIR DUCTS	1998	1,360		20	272	272	952	15
16	ELECTRICAL WORK	1998	697		20	139	139	488	16
17	ELECTRICAL WORK	1998	913		20	183	183	639	17
18	HEAT EXCHANGER REPLACED/DINING	1998	2,475		20	495	495	1,733	18
19	REPAIR #22 HVAC	1998	608		20	122	122	426	19
20	REPAIR #2 HVAC	1998	1,120		20	224	224	784	20
21	BATHTUB PLUMBING	1998	509		20	102	102	356	21
22	ICE MACHINE REPAIR IN MAIN KIT	1998	285		20	57	57	200	22
23	ICE MACHINE REPAIRS IN NORTH D	1998	293		20	59	59	205	23
24	STEAMER REPAIRS	1998	449		20	90	90	314	24
25	REPAIRED 1-DOOR REACH-IN FREEZ	1998	182		20	36	36	127	25
26	ELECTRICAL WORK	1998	1,630		20	326	326	1,141	26
27	ALLEY DOOR 15 SECOND ALARM	1998	1,043		20	209	209	730	27
28	HVAC #22	1998	551		20	110	110	386	28
29	NORTON DOOR CLOSER/HOLDERS (4)	1998	2,218		20	444	444	1,553	29
30	BATH STATIONS (N76 & N77)	1998	514		20	103	103	360	30
31	GARBAGE GRINDER	1998	2,226		20	445	445	1,558	31
32	SOLENOID VALVE FOR GARBAGE DIS	1998	274		20	55	55	192	32
33	(10) 4' 2 LITE FIXTURES & LABO	1998	1,423		20	285	285	996	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 6,623,874	\$ 258,715		\$ 225,233	\$ (33,482)	\$ 2,588,437	34

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

Facility Name & ID Number PROVENA ST ANNE CENTER# 0041731

Report Period Beginning:

01/01/01

Ending:

12/31/01**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12C, Carried Forward</b>		\$ 6,623,874	\$ 258,715		\$ 225,233	\$ (33,482)	\$ 2,588,437	1
2	WANDER GUARD & REMOTE LIGHT/SO	1998	1,533		20	307	307	1,073	2
3	REPAIR FIRE SPRINKLER SYSTEM	1999	756		20	151	151	378	3
4	CEILING REPAIR	1999	850		20	170	170	425	4
5	PUSHBUTTON LOCK ON STORAGE ROO	1999	553		20	111	111	276	5
6	HEATING UNIT #7 REPAIRS	1999	1,221		20	244	244	611	6
7	EVAPORATOR COIL/KITCHEN FREEZE	1999	918		20	184	184	459	7
8	CARPET & INSTALLATION	1999	358		20	72	72	179	8
9	ELECTRICAL WORK (HEATER & OUTL	1999	785		20	157	157	393	9
10	VINYL STOCK	1999	5,460		20	1,092	1,092	2,730	10
11	TIE CONTACTOR FOR AIR CONDITIO	1999	379		20	76	76	190	11
12	HVAC BLOWER MOTER & CAPACITOR	1999	345		20	69	69	173	12
13	HVAC MOTOR ASSEMBLY, CONTROLLE	1999	672		20	134	134	336	13
14	CHAINLINK PARTITION W/GATE (OX	1999	2,670		20	534	534	1,335	14
15	VAPOR LAMPS & EXTERIOR SIGN	1999	1,170		20	234	234	585	15
16	KITCHEN HALLWAY WALL REPAIRS	1999	942		20	188	188	471	16
17	FOUR 2x4 GRID FIXTURES W/LAMPS	1999	1,131		20	226	226	566	17
18	HOT WATER LOOP REPAIR (WEST WI	1999	717		20	239	239	598	18
19	ROOF REPAIRS	1999	600		20	120	120	300	19
20	ROOFTOP REPAIRS	1999	600		20	60	60	150	20
21	GIARDONO'S PAINTING	2000	417		20	83	83	125	21
22	SMOKE DETECTOR & BASE	2000	505		20	101	101	152	22
23	GRATES FOR KITCHEN FLOOR SINKS	2000	1,220		20	244	244	366	23
24	PAINT RESIDENT UNIT #D-31	2000	600		20	120	120	180	24
25	PAINT THERAPY ROOMS	2000	725		20	145	145	218	25
26	PAINT D-35 RESIDENTS HOME ROOM	2000	200		20	40	40	60	26
27	HOT WATER HEATER (A O SMITH)	2000	4,950		20	495	495	743	27
28	SOAOUTH MIXING VALVES REPAIRS	2000	1,082		20	216	216	325	28
29	REPAIR LEAK IN ROOF	2000	828		20	166	166	248	29
30	REPAIR LEAK IN ROOM	2000	582		20	116	116	174	30
31	REPAIRED LEAK IN HALL BY SWITC	2000	474		20	95	95	142	31
32	PAINT RESIDENTS WALLS (F-58 &	2000	400		20	80	80	120	32
33	CARPET FOR NUTRITION ROOM	2000	466		20	93	93	140	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 6,657,983	\$ 258,715		\$ 231,595	\$ (27,120)	\$ 2,602,655	34

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

Facility Name & ID Number PROVENA ST ANNE CENTER# 0041731

Report Period Beginning:

01/01/01

Ending:

12/31/01**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12D, Carried Forward</b>		\$ 6,657,983	\$ 258,715		\$ 231,595	\$ (27,120)	\$ 2,602,655	1
2	DOOR ALARM "VOICE ANNOUNCE"	2000	5,723		20	1,145	1,145	1,717	2
3	PAINT - 15 GAL	2000	246		20	49	49	74	3
4	PAINT D-29 & B-14 RESIDENT WAL	2000	400		20	80	80	120	4
5	PAINT W-87 & NORTH WING NURSES	2000	395		20	79	79	119	5
6	PAINT A-5 & W-87 RESIDENTS WAL	2000	225		20	45	45	68	6
7	PAINT W-89 RESIDENTS WALLS	2000	200		20	40	40	60	7
8	PAINT F-48 RESIDENTS WALLS	2000	200		20	40	40	60	8
9	PAINT F-52 RESIDENTS WALLS	2000	200		20	40	40	60	9
10	PAINT E-41 RESIDENTS WALLS	2000	200		20	40	40	60	10
11	PAINT OFFICE WALL	2000	250		20	50	50	75	11
12	PAINT W99,C20,MEDICATION RM	2000	272		20	54	54	81	12
13	MUSHROOM FLUORESCENT FIXTURES	2000	3,907		20	558	558	837	13
14	SIGNED REPAIRS	2000	1,053		20	211	211	316	14
15	CARPET	2000	323		20	65	65	97	15
16	PAINT RESIDENTS WALLS F49 & F5	2000	400		20	80	80	120	16
17	PAINT RESIDENT WALLS F56 & C18	2000	400		20	80	80	120	17
18	PAINT NUTRIATION ROOMS	2000	338		20	68	68	101	18
19	PAINT HALL CEILINGS	2000	688		20	138	138	207	19
20	PAINT SOUTH & EAST NUTRITION R	2000	338		20	68	68	101	20
21	EMERGENCY QUAD RECEPTACLE	2000	557		20	111	111	167	21
22	PAINT CONFERENCE ROOM WALLS	2000	150		20	30	30	45	22
23	MUSHROOM FLUORESCENT FIXTURES	2000	533		20	107	107	160	23
24	PAINT WALLS C-21 & C-24	2000	400		20	80	80	120	24
25	PAINT RESIDENT WALLS	2000	875		20	175	175	263	25
26	PAINT C-22 & C-27 RESIDENT WAL	2000	400		20	80	80	120	26
27	PAINT W-86,W-97,D-30 CARE PLAN	2000	775		20	155	155	233	27
28	DUPLEX RECEPTACLES (2) FOR LUN	2000	522		20	104	104	157	28
29	WATER VALVES/NORTH WING	2000	626		20	125	125	188	29
30	FRONT LOBBY PROJECT	2000	3,462		20	692	692	1,039	30
31	BURNER COANTROL, MIXED AIR MOT	2000	2,067		20	413	413	620	31
32	DISCHARGE AIR SENSOR	2000	1,247		20	249	249	374	32
33	PAINT RESIDENT WALLS W-88	2000	200		20	40	40	60	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 6,685,556	\$ 258,715		\$ 236,886	\$ (21,829)	\$ 2,610,592	34

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

Facility Name & ID Number PROVENA ST ANNE CENTER# 0041731

Report Period Beginning:

01/01/01

Ending:

12/31/01**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12E, Carried Forward</b>		\$ 6,685,556	\$ 258,715		\$ 236,886	\$ (21,829)	\$ 2,610,592	1
2	PAINT OFFICE WALLS	2000	535		20	107	107	161	2
3	SAC COMMON AREA ASSESSMENT	2000	1,623		20	325	325	487	3
4	REBUILD SOUTH WALL HYDRANT	2000	597		20	119	119	179	4
5	UNIT 17 HVAC REPAIRS	2000	654		20	131	131	196	5
6	CARPET - BEAUTY SHOP	2000	522		20	104	104	157	6
7	PAINT BEAUTY SHOP & B-9 RESIDE	2000	555		20	111	111	167	7
8	PAINT N-73 RESIDENTS WALLS	2000	225		20	45	45	68	8
9	PAINT B-15 & B-11 RESIDENTS WA	2000	400		20	80	80	120	9
10	PAINT RESIDENT WALLS (G-61,B-1	2000	550		20	110	110	165	10
11	PAINT A-8 RESIDENTS WALLS	2000	200		20	40	40	60	11
12	PAINT RESIDENTS WALLS (G-67,F-	2000	450		20	90	90	135	12
13	RGB MAJOR BUILDING CONSULTING	2000	5,712		20	571	571	857	13
14	RGB ARCHITECTURAL SERVICES	2000	425		20	142	142	213	14
15	RGB ARCHITECTURAL SERVICES	2000	1,198		20	240	240	359	15
16	RGB ARCHITECTURAL SERVICES	2000	521		20	104	104	156	16
17	RGB ARCHITECTURAL SERVICES	2000	4,037		20	807	807	1,211	17
18	RGB ARCHITECTURAL SERVICES	2000	964		20	193	193	289	18
19	RGB ARCHITECTURAL SERVICES	2000	250		20	50	50	75	19
20	REPAIR HVAC #20	2000	844		20	169	169	253	20
21	EVAPORATOR ASSEMBLY FOR WALK-I	2001	1,783		20	178	178	178	21
22	MOTOR,RAIN SHIELD, ETC FOR COO	2001	1,223		20	122	122	122	22
23	DRAIN/HEATER (WALK-IN FREEZER	2001	691		20	69	69	69	23
24	MOTOR,CAPACITOR,ETC (WALK-IN C	2001	2,136		20	214	214	214	24
25	REPLACED PRESSURE CONTROL (COO	2001	751		20	75	75	75	25
26	SIMPLEX COMBINATION LOCK	2001	266		20	27	27	27	26
27	NORTH HOT WATER HEATER MIXING	2001	1,424		20	142	142	142	27
28	WALK-IN FREEZER REPAIRS	2001	874		20	87	87	87	28
29	NORTH WALK-IN COOLER REPAIRS	2001	2,460		20	246	246	246	29
30	WALK-IN FREEZER REPAIRS	2001	846		20	85	85	85	30
31	REPLACE AIR COMPRESSOR-FIRE SP	2001	3,524		20	352	352	352	31
32	INSTALL FIRE ALARM - FRONT LOB	2001	14,772		20	1,477	1,477	1,477	32
33	HAVC #1, #2, #18 REPAIRS	2001	2,005		20	201	201	201	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 6,738,570	\$ 258,715		\$ 243,699	\$ (15,016)	\$ 2,619,174	34

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

Facility Name & ID Number PROVENA ST ANNE CENTER# 0041731

Report Period Beginning:

01/01/01

Ending:

12/31/01**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12F, Carried Forward</b>		\$ 6,738,570	\$ 258,715		\$ 243,699	\$ (15,016)	\$ 2,619,174	1
2	<u>PAINT N-WING WALLS</u>	2001	565		20	57	57	57	2
3	<u>3 WANDER GUARD SYSTEMS</u>	2001	735		20	74	74	74	3
4	<u>"B" WING DOOR CONTROL</u>	2001	1,595		20	160	160	160	4
5	<u>SOS POSTFORM CTOPS &amp; LAMINATES</u>	2001	1,110		20	79	79	79	5
6	<u>PAINT SOCIAL SERVICE &amp; PASTORA</u>	2001	325		20	33	33	33	6
7	<u>INSTALL NEW WATER SUPPLY LINES</u>	2001	589		20	59	59	59	7
8	<u>RECIRCULATING PUMP</u>	2001	1,241		20	124	124	124	8
9	<u>WATER LINE REPAIRS</u>	2001	1,115		20	111	111	111	9
10	<u>ROOFING REPAIRS</u>	2001	796		20	80	80	80	10
11	<u>PAINT PINK FRAMES</u>	2001	170		20	17	17	17	11
12	<u>THRU WALL UNITS &amp; FILTERS</u>	2001	9,245		20	925	925	925	12
13	<u>ROOFING REPAIRS</u>	2001	458		20	46	46	46	13
14	<u>ROOFING REPAIRS</u>	2001	916		20	92	92	92	14
15	<u>PAINT FOUND DIRECTOR OFFICE</u>	2001	209		20	21	21	21	15
16	<u>CRANKCASE HEATER, BREAKER, MIS</u>	2001	878		20	88	88	88	16
17	<u>BLOWER ASSEMBLY (HVAC #21)</u>	2001	868		20	87	87	87	17
18	<u>ROOFING REPAIRS</u>	2001	717		20	72	72	72	18
19	<u>ROOF REPAIRS</u>	2001	2,957		20	296	296	296	19
20	<u>PAINT WALLS (RESIDENT, BATH, R</u>	2001	600		20	60	60	60	20
21	<u>ROOF REPAIRS (SCUPPER)</u>	2001	749		20	75	75	75	21
22	<u>PAINT RESIDENTS WALLS (G62, G6</u>	2001	600		20	60	60	60	22
23	<u>PAINT RESIDENT WALLS, DINING R</u>	2001	660		20	66	66	66	23
24	<u>WALK-IN FREEZER CONDENSER #24</u>	2001	556		20	56	56	56	24
25	<u>NORTON POWER TRACK HOLDER/CLOS</u>	2001	557		20	56	56	56	25
26	<u>PAINT RESIDENTS WALLS</u>	2001	975		20	98	98	98	26
27	<u>BALLASTS (6) &amp; CIRCUIT BREAKER</u>	2001	614		20	61	61	61	27
28	<u>HOT WATER PIPING</u>	2001	694		20	69	69	69	28
29	<u>PAINT RESIDENT WALLS</u>	2001	450		20	45	45	45	29
30	<u>PAINT RESIDENTS WALLS &amp; WEST D</u>	2001	510		20	51	51	51	30
31	<u>HVAC #12 &amp; HVAC #20 REPAIRS</u>	2001	1,120		20	112	112	112	31
32	<u>INSTALL NW DOOR INTERCOM</u>	2001	1,186		20	119	119	119	32
33	<u>THRU THE WALL AIR CONDITIONERS</u>	2001	4,550		20	455	455	455	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 6,776,880	\$ 258,715		\$ 247,498	\$ (11,217)	\$ 2,622,973	34

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

Facility Name & ID Number PROVENA ST ANNE CENTER# 0041731

Report Period Beginning:

01/01/01

Ending:

12/31/01**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12G, Carried Forward</b>		\$ 6,776,880	\$ 258,715		\$ 247,498	\$ (11,217)	\$ 2,622,973	1
2	COMPLETED SIGNED REPAIRS	2001	880		20	88	88	88	2
3	ELECTRICAL WORK - NEW ENTRY AD	2001	583		20	58	58	58	3
4	WEATHERPROOF KEY PAD & PROGRAM	2001	230		20	23	23	23	4
5	LOBBY & MAIN ENTRANCE	2001	9,049		20	452	452	452	5
6	RESET SYSTEM & FIX LEAK IN CAF	2001	680		20	68	68	68	6
7	ROOF REPAIRS	2001	1,636		20	164	164	164	7
8	INSTALL NEW WATER SUPPLY LINES	2001	1,056		20	132	132	132	8
9	BASEMENT DOOR HOLDERS (2)	2001	723		20	72	72	72	9
10	REPLACED TOLIET & INSTALLATION	2001	652		20	65	65	65	10
11	BLOWER WHEELS & BEARINGS (2) C	2001	677		20	68	68	68	11
12	HOT WATER REPAIRS NORTH WING	2001	909		20	91	91	91	12
13	LOBBY IMPROVEMENTS	2001	8,927		20	446	446	446	13
14	SCANDROLI CONSTRUCTION - FRONT	2001	26,011		20	1,301	1,301	1,301	14
15	FRONT LOBBY & MAIN ENTRANCE -	2001	1,637		20	82	82	82	15
16	TEMPORARY ENTRANCE - FRONT LOB	2001	832		20	83	83	83	16
17	FRONT LOBBY - WANDER GUARD SYS	2001	140		20	35	35	35	17
18	SCANDROLI CONSTRUCTION SERVICE	2001	126,561		20	3,164	3,164	3,164	18
19	FRONT LOBBY EXPANSION	2001	67,538		20	3,377	3,377	3,377	19
20	INSTALLATION OF SIGNS - LOBBY	2001	693		20	69	69	69	20
21	TESTING ENGINEERS SERVICES	2001	470		20	47	47	47	21
22	LOBBY AREA SERVICES	2001	21,101		20	1,055	1,055	1,055	22
23	REPLACEMENT BLINDS FOR N WIN	2001	596		20	60	60	60	23
24	SEAL COATING OF FENCE IN PARK AREA B	2001	585		20	98	98	98	24
25	LANDSCAPE - NEW ENTRANCE	2001	1,271		20	635	635	635	25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 7,050,315	\$ 258,715		\$ 259,231	\$ 516	\$ 2,634,706	34

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

Facility Name & ID Number **PROVENA ST ANNE CENTER**

# **0041731**

Report Period Beginning:

01/01/01

Ending:

12/31/01

**XI. OWNERSHIP COSTS (continued)**

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	<b>Totals from Page 12H, Carried Forward</b>		\$ <b>7,050,315</b>	\$ <b>258,715</b>		\$ <b>259,231</b>	\$ <b>516</b>	\$ <b>2,634,706</b>	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	<b>TOTAL (lines 1 thru 33)</b>		\$ <b>7,050,315</b>	\$ <b>258,715</b>		\$ <b>259,231</b>	\$ <b>516</b>	\$ <b>2,634,706</b>	34

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

Facility Name & ID Number **PROVENA ST ANNE CENTER**

# **0041731**

Report Period Beginning:

**01/01/01**

Ending:

**12/31/01**

**XI. OWNERSHIP COSTS (continued)**

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
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

\*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-REP, Line 70 for total**

Facility Name & ID Number PROVENA ST ANNE CENTER

# 0041731

Report Period Beginning:

01/01/01

Ending:

12/31/01

**XI. OWNERSHIP COSTS (continued)**

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)		\$	\$	\$	\$	\$	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 689,656	\$ 96,683	\$ 96,683	\$ (0)	10	\$ 491,291	71
72	Current Year Purchases	39,116	3,025	3,025	(0)	10	3,025	72
73	Fully Depreciated Assets	5,875				10	5,875	73
74								74
75	TOTALS	\$ 734,647	\$ 99,708	\$ 99,707	\$ (1)		\$ 500,191	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident Transport	MINI-VAN	1998	\$ 43,500	\$ 8,700	\$ 8,700	\$	5	\$ 30,450	76
77	Maintenance	F150 FORD WITH SNOWPLOW	1999	23,172	7,724	7,724		5	19,310	77
78										78
79										79
80	TOTALS			\$ 66,672	\$ 16,424	\$ 16,424	\$		\$ 49,760	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)	\$ 8,496,988	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 374,847	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 375,363	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 516	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,184,657	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		\$	92
93			93
94			94
95		\$	95

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

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

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: 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 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6	<b>ALLOC-PROVENA SENIOR SERVICES</b>				<b>15,768</b>			6
7	<b>TOTAL</b>				<b>\$ 15,768</b>			7

\*\*

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

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

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

**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: \$ 605 Description: SEE ATTACHED

(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	<b>TOTAL</b>		\$	\$	21

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending Annual Rent

12. /2002 \$ \_\_\_\_\_

13. /2003 \$ \_\_\_\_\_

14. /2004 \$ \_\_\_\_\_

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

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

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

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

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

**ALLOCATION OF COSTS (d)**

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

**C. CONTRACTUAL INCOME**

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

\$ \_\_\_\_\_

**D. NUMBER OF AIDES TRAINED**

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the aide 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 aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides 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 aides.

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

	Service	1 Schedule V Line & Column Reference	2		3		4		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8	
			Staff		Cost	Outside Practitioner (other than consultant)		Total Cost (Col. 3 + 5 + 6)				
			Units of Service			Units	Cost					
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$	191,684	\$		\$	191,684	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				21,855				21,855	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39 - 03	hrs				215,669				215,669	4
5	Physician Care		visits									5
6	Dental Care		visits									6
7	Work Related Program		hrs									7
8	Habilitation		hrs									8
9	Pharmacy	39 - 02	# of prescripts					803,972			803,972	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Exceptional Care Program											12
13	Other (specify):							13,869			13,869	13
14	TOTAL			\$		\$	429,208	\$	817,841	\$	1,247,049	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 nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name &amp; ID Number      PROVENA ST ANNE CENTER

#      0041731

Report Period Beginning:      01/01/01

Ending:      12/31/01

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of      12/31/01

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 3,989,309	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	11,555,810		3
4	Supply Inventory (priced at )	447,185		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	424,582		7
8	Accounts Receivable (owners or related parties)	130,474		8
9	Other(specify): <a href="#">See supplemental schedule</a>	457,513		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 17,004,873	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	7,516,166		12
13	Land	7,818,584		13
14	Buildings, at Historical Cost	69,593,771		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	12,395,931		16
17	Accumulated Depreciation (book methods)	(33,036,528)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	72,837		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <a href="#">See supplemental schedule</a>	5,331,935		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 69,692,696	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 86,697,569	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 1,713,453	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	494,877		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	2,664,623		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	11,659		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<a href="#">See supplemental schedule</a>	636,912		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 5,521,524	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<a href="#">See supplemental schedule</a>	44,263,363		43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 44,263,363	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 49,784,887	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 36,912,682	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 86,697,569	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>34,695,680</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Adjustment to Reconcile Consolidated Opening Equity</b>	<b>1,576,083</b>	<b>3</b>
<b>4</b>	<b>and Consolidated Net Income to Nursing Facility</b>		<b>4</b>
<b>5</b>	<b>Amounts</b>		<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>36,271,763</b>	<b>6</b>
<b>A. Additions (deductions):</b>			
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>640,919</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>640,919</b>	<b>17</b>
<b>B. Transfers (Itemize):</b>			
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>36,912,682</b>	<b>24</b> *

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

Facility Name &amp; ID Number PROVENA ST ANNE CENTER

# 0041731

Report Period Beginning: 01/01/01

Ending:

12/31/01

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

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

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 7,734,772	1
2	Discounts and Allowances for all Levels	(5,130)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 7,729,642	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	737,653	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 737,653	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	6,183	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	936,065	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 942,248	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	82,551	24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 82,551	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See supplemental schedule</u>	2,301	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 2,301	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 9,494,395	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,449,275	31
32	Health Care	3,514,739	32
33	General Administration	2,120,246	33
<b>B. Capital Expense</b>			
34	Ownership	375,452	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	1,295,763	35
36	Provider Participation Fee	98,001	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 8,853,476	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	640,919	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 640,919	43

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? not complete 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 PROVENA ST ANNE CENTER

# 0041731

Report Period Beginning:

01/01/01

Ending:

12/31/01

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,848	2,146	\$ 59,454	\$ 27.70	1
2	Assistant Director of Nursing	1,768	1,872	43,173	23.06	2
3	Registered Nurses	33,839	36,792	704,654	19.15	3
4	Licensed Practical Nurses	36,427	39,387	598,371	15.19	4
5	Nurse Aides & Orderlies	107,825	115,656	1,217,775	10.53	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,760	7,394	90,168	12.19	8
9	Activity Director	1,056	1,316	15,861	12.05	9
10	Activity Assistants	7,723	8,175	77,058	9.43	10
11	Social Service Workers	8,908	10,080	131,363	13.03	11
12	Dietician					12
13	Food Service Supervisor	3,412	4,008	62,603	15.62	13
14	Head Cook	8,440	9,333	100,665	10.79	14
15	Cook Helpers/Assistants	24,245	25,588	185,274	7.24	15
16	Dishwashers					16
17	Maintenance Workers	4,247	4,717	72,187	15.30	17
18	Housekeepers	21,595	23,564	200,779	8.52	18
19	Laundry	3,858	4,235	29,950	7.07	19
20	Administrator	1,840	2,144	84,733	39.52	20
21	Assistant Administrator	1,818	2,080	50,883	24.46	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,402	12,715	147,259	11.58	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director	7,154	7,834	93,896	11.99	27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)	1,946	2,400	35,475	14.78	33
34	TOTAL (lines 1 - 33)	296,111	321,436	\$ 4,001,581 *	\$ 12.45	34

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	\$ 14,343	01-03	35
36	Medical Director	16,670	09-03	36
37	Medical Records Consultant			37
38	Nurse Consultant	1,506	10-03	38
39	Pharmacist Consultant			39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant	3,141	11-03	44
45	Social Service Consultant			45
46	Other(specify)			46
47	<u>SOCIAL WORK CONSULTANT</u>	945	12-03	47
48	<u>PASTORAL CONSULTANT</u>	8,660	12-03	48
49	TOTAL (lines 35 - 48)	\$ 45,265		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	\$ 5,678	10-03	50
51	Licensed Practical Nurses	18,487	10-03	51
52	Nurse Aides	143,071	10-03	52
53	TOTAL (lines 50 - 52)	\$ 167,236		53

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

\*\* See instructions.



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

(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	<b>TOTALS</b>	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number PROVENA ST ANNE CENTER# 0041731Report Period Beginning: 01/01/01Ending: 12/31/01**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? YES  
If YES, give association name and amount. LSN \$4031
- (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? \_\_\_\_\_
- (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? \_\_\_\_\_
- (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? 10 YEARS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 66,643 Line 10-2
- (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. \_\_\_\_\_
- (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 of Public Aid during this cost report period. \$ 98,001  
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 of Public Aid, 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 benefit: on Schedule V. \$ 0 Has any meal income been offset against related costs? \_\_\_\_\_ Indicate the amount. \$ \_\_\_\_\_
- (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. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? NONE  
d. Have vehicle usage logs been maintained? NO  
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.** \$ \_\_\_\_\_
- (17) Has an audit been performed by an independent certified public accounting firm? YES  
Firm Name: KPMG The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? NO If no, please explain. NOT AVAILABLE
- (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 \$2500, 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