

		FOR BHF USE					

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2006
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2006)

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

I. IDPH Facility ID Number: 0041731

Facility Name: Provena St Anne Center

Address: 4405 Highcrest Road Rockford 61107
 Number City Zip Code

County: Winnebago

Telephone Number: (815) 299-1999 **Fax #** (815) 299-1560

HFS ID Number: 371127787010

Date of Initial License for Current Owners: 10/6/86

Type of Ownership:

<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code <u>501 c 3</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

In the event there are further questions about this report, please contact:
Name: Lynda Olinski **Telephone Number:** (708) 478-7916

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/06 to 12/31/06 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider	(Signed) _____	(Date) _____
	(Type or Print Name) <u>Michael R. Gordon</u>	
	(Title) <u>VP of Finance, CFO</u>	
Paid Preparer	(Signed) _____	(Date) _____
	(Print Name and Title) _____	
	(Firm Name & Address) _____	
	(Telephone) (____) _____ Fax # (____) _____	

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

Facility Name & ID Number Provena St Anne Center

0041731 Report Period Beginning: 01/01/06 Ending: 12/31/06

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 _____

	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				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	19,953		19,398	39,351	8
9	SNF/PED					9
10	ICF		19,591		19,591	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	19,953	19,591	19,398	58,942	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.22%

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

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

N/A - 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 10/6/86

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 119 and days of care provided 16,008

Medicare Intermediary Administar Federal

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/06 Fiscal Year: 12/31/06

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

Facility Name & ID Number Provena St Anne Center # 0041731 Report Period Beginning: 01/01/06 Ending: 12/31/06

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	
	A. General Services											
1	Dietary	423,782	65,366	41,177	530,325		530,325		530,325			1
2	Food Purchase		349,037		349,037		349,037	4,766	353,803			2
3	Housekeeping	134,567	23,613	101	158,281		158,281		158,281			3
4	Laundry	8,632	7,438	140,578	156,648		156,648		156,648			4
5	Heat and Other Utilities			158,383	158,383		158,383	1,643	160,026			5
6	Maintenance	144,201	36,099	48,617	228,917		228,917	63,062	291,979			6
7	Other (specify):* Pastoral Care	42,666	1,401	14,639	58,706		58,706	(2,943)	55,763			7
8	TOTAL General Services	753,848	482,954	403,495	1,640,297		1,640,297	66,528	1,706,825			8
	B. Health Care and Programs											
9	Medical Director			19,200	19,200		19,200		19,200			9
10	Nursing and Medical Records	4,354,285	378,109	424,705	5,157,099		5,157,099		5,157,099			10
10a	Therapy			1,053,332	1,053,332		1,053,332		1,053,332			10a
11	Activities	116,479	4,247	10,063	130,789		130,789	1,895	132,684			11
12	Social Services	99,522	16	472	100,010		100,010		100,010			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	4,570,286	382,372	1,507,772	6,460,430		6,460,430	1,895	6,462,325			16
	C. General Administration											
17	Administrative	361,318	39,793	1,107,240	1,508,351		1,508,351	(566,064)	942,287			17
18	Directors Fees											18
19	Professional Services			53,792	53,792		53,792	399,044	452,836			19
20	Dues, Fees, Subscriptions & Promotions			86,850	86,850		86,850	(40,539)	46,311			20
21	Clerical & General Office Expenses			111,538	111,538		111,538	(296,063)	(184,525)			21
22	Employee Benefits & Payroll Taxes			1,073,568	1,073,568		1,073,568	173,586	1,247,154			22
23	Inservice Training & Education			13,911	13,911		13,911	5,722	19,633			23
24	Travel and Seminar			13,835	13,835		13,835	8,609	22,444			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			177,270	177,270		177,270	211	177,481			26
27	Other (specify):* Bad Debt			209,633	209,633		209,633	(209,633)				27
28	TOTAL General Administration	361,318	39,793	2,847,637	3,248,748		3,248,748	(525,127)	2,723,621			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,685,452	905,119	4,758,904	11,349,475		11,349,475	(456,704)	10,892,771			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: 01/01/06 Ending: 12/31/06

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	
	D. Ownership											
30	Depreciation			326,342	326,342	326,342	141,181	467,523				30
31	Amortization of Pre-Op. & Org.											31
32	Interest						262,968	262,968				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds						20,713	20,713				34
35	Rent-Equipment & Vehicles			11,092	11,092	11,092	1,863	12,955				35
36	Other (specify):*											36
37	TOTAL Ownership			337,434	337,434	337,434	426,725	764,159				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			949,981	949,981	949,981		949,981				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			98,003	98,003	98,003		98,003				42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			1,047,984	1,047,984	1,047,984		1,047,984				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,685,452	905,119	6,144,322	12,734,893	12,734,893	(29,979)	12,704,914				45

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

Facility Name & ID Number Provena St Anne Center

0041731

Report Period Beginning: 01/01/06

Ending: 12/31/06

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	16,945	30		9
10	Interest and Other Investment Income	(9,368)	32		10
11	Discounts, Allowances, Rebates & Refunds	(309,838)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(209,633)	27		24
25	Fund Raising, Advertising and Promotional	(51,537)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (563,431)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	536,395		34
35	Other- Attach Schedule	(2,943)		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 533,452		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (29,979)		37

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

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

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

BHF USE ONLY						
48		49		50		51
						52

Provena St Anne Center

ID# 0041731

Report Period Beginning: 01/01/06

Ending: 12/31/06

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Development Office Supplies	\$ (605)	7	1
2	Development Misc.	(2,338)	7	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(2,943)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Provena St Anne Center

0041731

Report Period Beginning:

01/01/06

Ending:

12/31/06

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	4,766	0	0	0	0	0	0	0	0	0	4,766	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	1,643	0	0	0	0	0	0	0	0	0	1,643	5
6	Maintenance	0	325	62,737	0	0	0	0	0	0	0	0	63,062	6
7	Other (specify):*	(2,943)	0	0	0	0	0	0	0	0	0	0	(2,943)	7
8	TOTAL General Services	(2,943)	6,734	62,737	0	66,528	8							
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	1,895	0	0	0	0	0	0	0	0	0	1,895	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	1,895	0	0	0	0	0	0	0	0	0	1,895	16
	C. General Administration													
17	Administrative	0	(463,069)	(102,995)	0	0	0	0	0	0	0	0	(566,064)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	44,570	354,474	0	0	0	0	0	0	0	0	399,044	19
20	Fees, Subscriptions & Promotions	(51,537)	10,998	0	0	0	0	0	0	0	0	0	(40,539)	20
21	Clerical & General Office Expenses	(309,838)	13,775	0	0	0	0	0	0	0	0	0	(296,063)	21
22	Employee Benefits & Payroll Taxes	0	71,519	102,067	0	0	0	0	0	0	0	0	173,586	22
23	Inservice Training & Education	0	5,722	0	0	0	0	0	0	0	0	0	5,722	23
24	Travel and Seminar	0	8,609	0	0	0	0	0	0	0	0	0	8,609	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	211	0	0	0	0	0	0	0	0	0	211	26
27	Other (specify):*	(209,633)	0	0	0	0	0	0	0	0	0	0	(209,633)	27
28	TOTAL General Administration	(571,008)	(307,665)	353,546	0	(525,127)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(573,951)	(299,036)	416,283	0	(456,704)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Provena St Anne Center

0041731

Report Period Beginning:

01/01/06 Ending:

12/31/06

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	16,945	0	124,236	0	0	0	0	0	0	0	0	141,181	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(9,368)	0	272,336	0	0	0	0	0	0	0	0	262,968	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	20,713	0	0	0	0	0	0	0	0	20,713	34
35	Rent-Equipment & Vehicles	0	0	1,863	0	0	0	0	0	0	0	0	1,863	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	7,577	0	419,148	0	426,725	37							
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(566,374)	(299,036)	835,431	0	(29,979)	45							

Facility Name & ID Number Provena St Anne Center

0041731

Report Period Beginning:

01/01/06

Ending:

12/31/06

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
		See Attached		See Attached		

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)
1	V	2 Food	\$	Provena Senior Services	100.00%	\$ 4,766	\$ 4,766 1
2	V	5 Utilities		Provena Senior Services	100.00%	1,643	1,643 2
3	V	6 Maintenance - Other		Provena Senior Services	100.00%	325	325 3
4	V	11 Activities-Special Events		Provena Senior Services	100.00%	1,895	1,895 4
5	V	17 Admin - Misc. Other	742,800	Provena Senior Services	100.00%	15,504	(727,296) 5
6	V	17 Administrative Services		Provena Senior Services	100.00%	264,227	264,227 6
7	V	19 Professional Salaries		Provena Senior Services	100.00%	44,570	44,570 7
8	V	20 Dues,Subscriptions		Provena Senior Services	100.00%	10,998	10,998 8
9	V	21 Clerical Supplies		Provena Senior Services	100.00%	13,775	13,775 9
10	V	22 Employee Benefits		Provena Senior Services	100.00%	71,519	71,519 10
11	V	23 Education/Conference		Provena Senior Services	100.00%	5,722	5,722 11
12	V	24 Travel		Provena Senior Services	100.00%	8,609	8,609 12
13	V	26 Insurance		Provena Senior Services	100.00%	211	211 13
14	Total		\$ 742,800			\$ 443,764	\$ * (299,036) 14

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

Facility Name & ID Number Provena St Anne Center # 0041731 Report Period Beginning: 01/01/06 Ending: 12/31/06

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	30 Depreciation	\$	Provena Senior Services		\$ 4,249	\$ 4,249	15
16	V	32 Interest		Provena Senior Services		272,336	272,336	16
17	V	34 Rent - Facility		Provena Senior Services		20,713	20,713	17
18	V	35 Rent - Equipment		Provena Senior Services		1,863	1,863	18
19	V	17 Admin Salaries	174,360	Provena Health Services		110,491	(63,869)	19
20	V	22 Employee Benefits		Provena Health Services		43,135	43,135	20
21	V	30 Depreciation		Provena Health Services		119,987	119,987	21
22	V	19 Admin Consulting,Other		Provena Health Services		354,474	354,474	22
23	V	17 Information Systems Salaries	190,080	Provena Health Services		26,777	(163,303)	23
24	V	22 Information Systems Benefits		Provena Health Services		10,454	10,454	24
25	V	6 Information Systems - Equip Maint		Provena Health Services		17,263	17,263	25
26	V	17 Admin Salaries		Provena Health Services		74,271	74,271	26
27	V	22 Employee Benefits		Provena Health Services		28,995	28,995	27
28	V	17 Information Systems Salaries		Provena Health Services		49,906	49,906	28
29	V	22 Information Systems Benefits		Provena Health Services		19,483	19,483	29
30	V	6 Information Systems - Equip Maint		Provena Health Services		45,474	45,474	30
31	V	39 Ancillary Services - Other	949,981	Provena Senior Services Pharmacy		949,981		31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 1,314,421			\$ 2,149,852	\$ * 835,431	39

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

Facility Name & ID Number

Provena St Anne Center

0041731

Report Period Beginning:

01/01/06

Ending:

12/31/06

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									\$	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:

01/01/06

Ending: 12/31/06

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

Name of Related Organization Provena Senior Services
 Street Address 19065 Hickory Creek Drive, Ste 310
 City / State / Zip Code Mokena, IL60448
 Phone Number (708)478-7900
 Fax Number (708)478-5387

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

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	2	Food	Management Fee Income 5,596,693	20	\$ 35,910	\$	742,800	\$ 4,766	1
2	5	Utilities	Management Fee Income 5,596,693	20	12,383		742,800	1,643	2
3	6	Maintenance - Other	Management Fee Income 5,596,693	20	2,446		742,800	325	3
4	11	Activities-Special Events	Management Fee Income 5,596,693	20	14,275		742,800	1,895	4
5	17	Admin - Misc. Other	Management Fee Income 5,596,693	20	116,818		742,800	15,504	5
6	17	Administrative Salaries	Management Fee Income 5,596,693	20	1,990,843	1,990,843	742,800	264,227	6
7	19	Professional Services	Management Fee Income 5,596,693	20	335,820		742,800	44,570	7
8	20	Dues,Subscriptions	Management Fee Income 5,596,693	20	82,869		742,800	10,998	8
9	21	Clerical Supplies	Management Fee Income 5,596,693	20	103,786		742,800	13,775	9
10	22	Employee Benefits	Management Fee Income 5,596,693	20	538,870		742,800	71,519	10
11	23	Education/Conference	Management Fee Income 5,596,693	20	43,116		742,800	5,722	11
12	24	Travel	Management Fee Income 5,596,693	20	64,864		742,800	8,609	12
13	26	Insurance	Management Fee Income 5,596,693	20	1,591		742,800	211	13
14	30	Depreciation	Management Fee Income 5,596,693	20	32,015		742,800	4,249	14
15	32	Interest	Management Fee Income 5,596,693	20	2,051,940		742,800	272,336	15
16	34	Rent - Facility	Management Fee Income 5,596,693	20	156,067		742,800	20,713	16
17	35	Rent - Equipment	Management Fee Income 5,596,693	20	14,036		742,800	1,863	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 5,597,649	\$ 1,990,843		\$ 742,925	25

Facility Name & ID Number Provena St Anne Center

0041731

Report Period Beginning:

01/01/06

Ending: 12/31/06

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 Services
 Street Address 9223 West St. Francis Road
 City / State / Zip Code Frankfort, 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	17	Admin Salaries	Operating Expense	1,192,116	10	\$ 755,436	\$ 755,436	174,360	\$ 110,491	1
2	22	Employee Benefits	Operating Expense	1,192,116	10	294,918		174,360	43,135	2
3	30	Depreciation	Operating Expense	1,192,116	10	820,363		174,360	119,987	3
4	19	Admin Consulting,Other	Operating Expense	1,192,116	10	2,423,574		174,360	354,474	4
5	17	Information Systems Salaries	Operating Expense	1,301,820	10	183,390	183,390	190,080	26,777	5
6	22	Information Systems Benefits	Operating Expense	1,301,820	10	71,595		190,080	10,454	6
7	6	Information Systems - Equip Main	Operating Expense	1,301,820	10	118,233		190,080	17,263	7
8	17	Admin Salaries	Direct Cost	1,192,116	10	507,799	507,799	174,360	74,271	8
9	22	Employee Benefits	Direct Cost	1,192,116	10	198,242		174,360	28,995	9
10	17	Information Systems Salaries	Direct Cost	1,301,820	10	341,798	341,798	190,080	49,906	10
11	22	Information Systems Benefits	Direct Cost	1,301,820	10	133,436		190,080	19,483	11
12	6	Information Systems - Equip Main	Direct Cost	1,301,820	10	311,444		190,080	45,474	12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 6,160,228	\$ 1,788,423		\$ 900,710	25

Facility Name & ID Number Provena St Anne Center

0041731

Report Period Beginning:

01/01/06

Ending: 12/31/06

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	39	Ancillary Services - Other	Direct Allocation		\$	\$		\$ 949,981	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				\$	\$		\$ 949,981	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1										1										
2										2										
3										3										
4										4										
5										5										
Working Capital																				
6										6										
7										7										
8										8										
9	TOTAL Facility Related					\$	\$		\$	9										
B. Non-Facility Related*																				
10	Provena Senior Services									262,968	10									
11											11									
12											12									
13											13									
14	TOTAL Non-Facility Related					\$	\$		\$	262,968	14									
15	TOTALS (line 9+line14)					\$	\$		\$	262,968	15									

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # _____

* 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.)

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2005 report.		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	2
3. Under or (over) accrual (line 2 minus line 1).			\$	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:				
2001	_____	8		
2002	_____	9		
2003	_____	10		
2004	_____	11		
2005	_____	12		
			FOR BHF USE ONLY	
13	FROM R. E. TAX STATEMENT FOR 2005	\$		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:** 2005 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 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 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 Bureau of Health Finance at (217) 782-1630.

2005 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 _____

TELEPHONE (____) _____ FAX #: (____) _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2005 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 2005.

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

B. Real Estate Tax Cost Allocations

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

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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

Facility Name & ID Number Provena St Anne Center

0041731 Report Period Beginning:

01/01/06 Ending:

12/31/06

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, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Nursing Home</u>		<u>1985</u>	<u>\$ 645,354</u>	1
2					2
3	TOTALS			\$ 645,354	3

Facility Name & ID Number Provena St Anne Center

0041731

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	120			1986	\$ 3,516,907	\$ 100,483	35	\$ 100,483	\$ (0)	\$ 2,138,281	4
5	59			1992	2,722,251	90,742	10	90,742		1,216,705	5
6											6
7											7
8											8
Improvement Type**											
9	Various			1987	3,173	127	25	127		2,411	9
10	Various			1990	36,288	1,122	31	1,122		20,018	10
11	Various			1995	43,992	1,271	25	1,271		25,775	11
12	Various			1996	27,087	1,238	25	1,238		24,679	12
13	Various			1997	90,989	3,380	15	3,380		83,372	13
14	Various			1999	19,372	60	10	60		19,222	14
15	Various			2000	61,109	1,624	10	1,624		57,098	15
16	Various			2001	347,808	28,104	10	28,104		195,396	16
17	Various			2002	11,918	1,341	12	1,341		6,273	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, Line 70 for total

Facility Name & ID Number Provena St Anne Center

0041731

Report Period Beginning:

01/01/06

Ending:

12/31/06

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	
37	DESC: RENOVATION OF HALL AND CAFETERIA	2003	\$ 8,389	\$ 559	15	\$ 559	\$	\$ 1,957	37
38	DESC: REPLACEMENT WATER HEATER	2003	4,600	460	10	460		1,610	38
39	DESC: WATER HEATER	2003	5,030	503	10	503		1,761	39
40	DESC: WATER HEATER REPAIR	2003	156	31	5	31		110	40
41	DESC: CONDENSING UNIT	2003	7,100	710	10	710		2,485	41
42	DESC: REPLACEMENT CARPETING FOR CHAPEL	2003	3,633	727	5	727		2,543	42
43	DESC: HURD WINDOWS	2003	3,540	354	10	354		1,239	43
44	DESC: MAINTENANCE FOR GENERATOR	2003	1,145	229	5	229		801	44
45	DESC: DIETARY BLOWER	2003	2,575	258	10	258		901	45
46	DESC: SALVAJOR DISPOSER	2003	2,219	222	10	222		777	46
47	DESC: COMMERCIAL CEILING CLEANING	2003	575	115	5	115		345	47
48									48
49	DESC: FLAT ROOF REPAIR	2004	1,350	135	10	135		338	49
50	DESC: STRIP AND REAPPLY NEW WALLPAPER	2004	3,810	762	5	762		1,905	50
51	DESC: WATER VALVES	2004	2,200	147	15	147		367	51
52	DESC: ROOF REPAIR	2004	18,000	1,800	10	1,800		4,500	52
53	DESC: SEAL AND STRIPE PARKING LOT	2004	1,970	197	10	197		493	53
54	DESC: CATERPILLAR GENERATOR ANNUAL MAINTEN	2004	807		1			807	54
55	DESC: GENERATOR HOSES & BOLTS, EXHAUST COU	2004	1,911	382	5	382		955	55
56	DESC: GENERATOR- FLUSH COOLING SYSTEM,SEAL	2004	3,112	622	5	622		1,245	56
57	DESC: REPLACE RADIATOR BELTS / FLUSH AND R	2004	1,200	240	5	240		480	57
58	DESC: INSTALLATION OF AMPLIFIER & SPEAKER	2004	2,041	204	10	204		510	58
59	DESC: REPLACE WATER HEATER IN SOUTH UNIT	2004	6,700	670	10	670		1,675	59
60	DESC: WATER HEATER ON LOWER LEVEL	2004	5,330	533	10	533		1,066	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)		\$ 6,968,286	\$ 239,351		\$ 239,351	\$ (0)	\$ 3,818,100	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:

01/01/06

Ending:

12/31/06

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	Totals from Page 12A, Carried Forward		\$ 6,968,286	\$ 239,351		\$ 239,351	\$ (0)	\$ 3,818,100	1
2	DESC: H/M DOORS AND FRAMES	2005	1,481	74	20	74		111	2
3	DESC: REPAIR BROKEN SPRINKLER SYSTEM LINE	2005	1,530	306	5	306		459	3
4	DESC: DEMOLITION & DRYWALL	2005	2,841	284	10	284		426	4
5	DESC: REPLACE AIR COMPRESSOR	2005	1,984	165	12	165		248	5
6	DESC: REPLACE BREATHER, HOSES, AMPMETER, A	2005	1,462	209	7	209		313	6
7	DESC: DOOR CLOSURES	2005	1,772	177	10	177		266	7
8	DESC: 4'X6' ALUMINUM FRAMED MAGNETIC WHITE	2005	785	79	10	79		118	8
9	DESC: V14 SOLAR PROTECTIVE FILM APPLIED TO	2005	598	120	5	120		179	9
10	DESC: V14 SOLAR PROTECTIVE FIL 15 PANES WE	2005	582	58	10	58		87	10
11	DESC: 3 CRANK HURD WINDOWS	2005	5,745	575	10	575		862	11
12	DESC: PLUMBING FOR NEW BREAK ROOM SINK	2005	2,950	148	20	148		148	12
13	DESC: ELECTRICAL FOR NEW KITCHENETTE AND F	2005	4,279	285	15	285		285	13
14	DESC: REPLACE ROOF MOUNT MUA UNIT	2005	9,935	662	15	662		662	14
15	DESC: V14 SOLAR PROTECTIVE FIM APPLIED TO	2005	555	111	5	111		111	15
16									16
17	DESC: REPLACE PIPING	2006	1,359	45	15	91	45	45	17
18	DESC: HOLLOW METAL FRAMES AND DOORS	2006	585	15	20	29	15	15	18
19	DESC: OPEN CEILING FOR SPRINKLER REPAIR AN	2006	1,000	100	5	200	100	100	19
20	DESC: REPLACE CEILING TILES IN MAIN DINING	2006	4,000	200	10	400	200	200	20
21	DESC: VINYL SIDING ON GARAGE AND SEAMLESS	2006	4,365	146	15	291	146	146	21
22	DESC: CARPET IN 8 PATIENT ROOMS	2006	7,640	764	5	1,528	764	764	22
23	DESC: RUB RAILS	2006	2,051	103	10	205	103	103	23
24	DESC: WALK IN COOLER AND FREEZER / ROOFTOP	2006	30,100	1,003	15	2,007	1,003	1,003	24
25	DESC: TEKNOFLOR/VINYL BASE IN MAIN DINING	2006	22,100	1,105	10	2,210	1,105	1,105	25
26	DESC: REMOVE & REPAIR WATER DAMAGE AT SKY	2006	4,730	237	10	473	237	237	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,082,716	\$ 246,320		\$ 250,037	\$ 3,717	\$ 3,826,092	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: 01/01/06 Ending: 12/31/06

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	\$ 657,432	\$ 66,793	\$ 66,793	\$	13	\$ 255,783	71
72	Current Year Purchases	274,057	13,229	26,457	13,229	11	26,457	72
73	Fully Depreciated Assets	580,397					580,397	73
74	Home office allocation		124,236	124,236				74
75	TOTALS	\$ 1,511,886	\$ 204,258	\$ 217,486	\$ 13,229		\$ 862,637	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				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	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)	\$ 9,239,956	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 450,578	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 467,523	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 16,945	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,688,729	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.

Facility Name & ID Number Provena St Anne Center

0041731

Report Period Beginning: 01/01/06

Ending: 12/31/06

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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

If NO, see instructions.

YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ _____			3
4	Additions				_____			4
5	Home Office Allocation				20,713			5
6					_____			6
7	TOTAL				\$ 20,713			7

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.	_____ /2007	\$ _____
13.	_____ /2008	\$ _____
14.	_____ /2009	\$ _____

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: \$ 211,715 Description: Nursing \$192,727, Activities \$39, Plant Eng \$5,994, Admin \$11,092, Home Office \$1,863

(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	N/A		\$ _____	\$ _____	17
18			_____	_____	18
19			_____	_____	19
20			_____	_____	20
21	TOTAL		\$ _____	\$ _____	21

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Provena St Anne Center# 0041731

Report Period Beginning:

01/01/06

Ending:

12/31/06

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a,3	hrs	\$	9,465	\$ 494,069	\$	9,465	\$ 494,069	1
2	Licensed Speech and Language Development Therapist	10a,3	hrs		1,294	67,550		1,294	67,550	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a,3	hrs		9,420	491,713		9,420	491,713	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				949,981		949,981	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
14	TOTAL			\$	20,179	\$ 1,053,332	\$ 949,981	20,179	\$ 2,003,313	14

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

Facility Name & ID Number Provena St Anne Center# 0041731Report Period Beginning: 01/01/06

Ending:

12/31/06**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 12/31/06

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 9,196,621	\$	1
2	Cash-Patient Deposits	104,225		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	10,284,617		3
4	Supply Inventory (priced at)	527,496		4
5	Short-Term Investments			5
6	Prepaid Insurance	17,880		6
7	Other Prepaid Expenses	180,330		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 20,311,169	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	6,785,655		12
13	Land	6,865,930		13
14	Buildings, at Historical Cost	81,049,403		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	17,957,954		16
17	Accumulated Depreciation (book methods)	(48,335,409)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Goodwill</u>	126,984		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 64,450,517	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 84,761,686	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 3,462,064	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,875,684		28
29	Short-Term Notes Payable	38,451		29
30	Accrued Salaries Payable	2,295,855		30
31	Accrued Taxes Payable (excluding real estate taxes)	68,182		31
32	Accrued Real Estate Taxes(Sch.IX-B)	676,390		32
33	Accrued Interest Payable	32,958		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Due to Related Party</u>	595,505		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 9,045,089	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,289,822		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	276,292		42
	Other Long-Term Liabilities(specify):			
43	<u>Conditional Asset Retirement</u>	647,900		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,214,014	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 11,259,103	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 73,502,583	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 84,761,686	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 74,753,215	1
2	Restatements (describe):		2
3	Transfer to Affiliates	(3,000,000)	3
4	Adj. To reconcile consolidated equity & consolidated income	938,018	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 72,691,233	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	555,153	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock	85,263	9
10	Stock Options Exercised		10
11	Contributions and Grants	381,287	11
12	Expenditures for Specific Purposes	(210,353)	12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 811,350	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 73,502,583	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Provena St Anne Center

0041731

Report Period Beginning: 01/01/06

Ending: 12/31/06

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 9,691,161	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,691,161	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,739,241	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,739,241	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	7,209	13
14	Non-Patient Meals	1,142	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	163,215	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	7,468	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 179,034	23
D. Non-Operating Revenue			
24	Contributions	335,001	24
25	Interest and Other Investment Income***	9,368	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 344,369	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Purchase Rebates</u>	309,838	28
28a	<u>Misc. Income</u>	26,405	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 336,243	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 13,290,048	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,640,297	31
32	Health Care	6,460,430	32
33	General Administration	3,248,747	33
B. Capital Expense			
34	Ownership	337,435	34
C. Ancillary Expense			
35	Special Cost Centers	949,981	35
36	Provider Participation Fee	98,003	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 12,734,893	40
41	Income before Income Taxes (line 30 minus line 40)**	555,155	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 555,155	43

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

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

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

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

Facility Name & ID Number Provena St Anne Center

0041731

Report Period Beginning:

01/01/06

Ending:

12/31/06

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	1,928	2,040	\$ 96,546	\$ 47.33	1
2	Assistant Director of Nursing	2,032	2,080	66,402	31.92	2
3	Registered Nurses	25,130	26,988	700,939	25.97	3
4	Licensed Practical Nurses	58,550	63,056	1,429,661	22.67	4
5	CNAs & Orderlies	145,702	156,180	1,921,450	12.30	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	9,117	9,848	139,287	14.14	8
9	Activity Director	1,800	2,080	30,780	14.80	9
10	Activity Assistants	7,990	8,864	85,699	9.67	10
11	Social Service Workers	5,937	6,325	99,522	15.73	11
12	Dietician	3,556	3,866	74,280	19.21	12
13	Food Service Supervisor	3,183	3,373	53,495	15.86	13
14	Head Cook	10,187	10,818	119,230	11.02	14
15	Cook Helpers/Assistants	22,826	23,523	176,777	7.52	15
16	Dishwashers					16
17	Maintenance Workers	8,285	8,852	144,201	16.29	17
18	Housekeepers	14,772	15,656	134,567	8.60	18
19	Laundry	1,101	1,182	8,632	7.30	19
20	Administrator	1,864	2,080	102,843	49.44	20
21	Assistant Administrator	1,952	2,080	52,212	25.10	21
22	Other Administrative	4,631	5,030	80,160	15.94	22
23	Office Manager	1,736	1,942	36,172	18.63	23
24	Clerical	6,748	7,152	89,931	12.57	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>Pastoral Care</u>	2,179	2,371	42,666	17.99	33
34	TOTAL (lines 1 - 33)	341,206	365,386	\$ 5,685,452 *	\$ 15.56	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	662	\$ 38,891	1,3	35
36	Medical Director	\$1600/mo	19,200	9,3	36
37	Medical Records Consultant	31	1,378	10,3	37
38	Nurse Consultant				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	58	3,117	11,3	44
45	Social Service Consultant	8	472	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	759	\$ 63,058		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	1,198	\$ 50,861	10,3	50
51	Licensed Practical Nurses	4,035	146,037	10,3	51
52	Certified Nurse Assistants/Aides	54	1,350	10,3	52
53	TOTAL (lines 50 - 52)	5,287	\$ 198,248		53

Facility Name & ID Number Provena St Anne Center

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Report Period Beginning: 01/01/06

Ending: 12/31/06

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Janelle Chadwick	Administrator	0	\$ 102,843	Workers' Compensation Insurance	\$ 108,000	IDPH License Fee	\$	
Administrative Staff	Asst Administrator	0	52,212	Unemployment Compensation Insurance	18,765	Advertising: Employee Recruitment		
Administrative Staff	Office Manager	0	36,172	FICA Taxes	412,136	Health Care Worker Background Check		
Administrative Staff	Human Resources	0	35,711	Employee Health Insurance	324,434	(Indicate # of checks performed <u>123</u>)		
Administrative Staff	Receptionist	0	56,226	Employee Meals		Patient Background Checks	591	
Administrative Staff	Admin Asst	0	33,705	Illinois Municipal Retirement Fund (IMRF)*		Employee Recruitment	20,624	
Administrative Staff	Admissions	0	44,449	Life Insurance	25,577	Dues & Subscription	10,675	
TOTAL (agree to Schedule V, line 17, col. 1)				Pension	149,400	Advertising & Public Relations	55,551	
(List each licensed administrator separately.)			\$ 361,318	Employee Recognition	4,512			
B. Administrative - Other				Executive Benefits	6,735	Home Office Allocation	10,998	
Description			Amount	Employee Screening	24,009	Less: Public Relations Expense	()	
Corp Service Fee			\$ 174,360	Home Office Allocation	173,586	Non-allowable advertising	(51,537)	
Corp Service IS Fee			190,080			Yellow page advertising	()	
Mgmt Fee			516,000	TOTAL (agree to Schedule V, line 22, col.8)			\$ 1,247,154	
Mgmt Fee Interest			226,800	E. Schedule of Non-Cash Compensation Paid to Owners or Employees				
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 1,107,240	Description	Line #	Amount		
(Attach a copy of any management service agreement)				N/A		\$		
C. Professional Services				G. Schedule of Travel and Seminar**				
Vendor/Payee	Type		Amount	Description			Amount	
Legal Expense	Various		\$ 23,728	Out-of-State Travel			\$	
Survey & Analytical Tools	Various		12,131					
Transportation	Various		4,324	In-State Travel			13,835	
Gift Shop	Various		7,200					
Shredding	Various		504	Seminar Expense				
Plan Review Fee	Various		2,400					
Outsourced Services	Various		2,792	Home Office Allocation			8,609	
Collection Expense	Various		713	Entertainment Expense			()	
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL (agree to Sch. V, line 24, col. 8)			\$ 22,444	
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 53,792	TOTAL			\$	

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Provena St Anne Center

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. 7783 - Life Service Network
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? Yes If YES, what is the capacity? 179
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 7 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 67,331 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 98,003
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ No Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? N/A
- d. Have vehicle usage logs been maintained? N/A
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: 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 issued yet
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.