

		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: 0023390

Facility Name: St Ann's Healthcare Center

Address: 770 State Street Chester 62233
 Number City Zip Code

County: _____

Telephone Number: 618-826-2314 **Fax #** 618-826-2316

HFS ID Number: 37-1023098001

Date of Initial License for Current Owners: 03-01-1997

Type of Ownership:

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input 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 _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input checked="" 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: Mike Greer **Telephone Number:** 618-826-2314

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01-01-2006 to 12-31-2006 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) _____	
Paid Preparer	(Title) _____	
	(Signed) _____	(Date) _____
Paid Preparer	(Print Name and Title) <u>David Reis</u> <u>President</u>	
	(Firm Name & Address) <u>WDM Computer Services Inc.</u> <u>1900 Harrison St. Quincy, ILL 62301</u>	
	(Telephone) <u>217-228-1950</u> Fax # <u>217-222-6053</u>	
	MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	

Facility Name & ID Number St Ann's Healthcare Center

0023390 Report Period Beginning: 01-01-2006 Ending: 12-31-2006

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	<u>32</u>	Skilled (SNF)	<u>32</u>	<u>11,680</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>87</u>	Intermediate (ICF)	<u>87</u>	<u>31,755</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>119</u>	TOTALS	<u>119</u>	<u>43,435</u>	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	<u>1,842</u>		<u>2,998</u>	<u>4,840</u>	8
9	SNF/PED					9
10	ICF	<u>10,793</u>	<u>8,498</u>		<u>19,291</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>12,635</u>	<u>8,498</u>	<u>2,998</u>	<u>24,131</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 55.56%

D. How many bed-hold days during this year were paid by the Department?

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 03-01-1997

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 32 and days of care provided _____

Medicare Intermediary Mutual Of Omaha

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 2006 Fiscal Year: _____

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

Facility Name & ID Number St Ann's Healthcare Center # 0023390 Report Period Beginning: 01-01-2006 Ending: 12-31-2006

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	244,581	8,720	6,731	260,032		260,032		260,032		1
2	Food Purchase		122,242		122,242	(13,793)	108,449	(7,955)	100,494		2
3	Housekeeping	59,909	13,948		73,857		73,857		73,857		3
4	Laundry	53,914	6,591		60,505		60,505		60,505		4
5	Heat and Other Utilities			101,100	101,100		101,100		101,100		5
6	Maintenance	47,713	23,351	55,994	127,058		127,058		127,058		6
7	Other (specify):*										7
8	TOTAL General Services	406,117	174,852	163,825	744,794	(13,793)	731,001	(7,955)	723,046		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	948,773	173,437	6,219	1,128,429		1,128,429	(12,783)	1,115,646		10
10a	Therapy			289,202	289,202		289,202		289,202		10a
11	Activities	50,613	6,085	1,671	58,369		58,369		58,369		11
12	Social Services	33,262	922	3,827	38,011		38,011		38,011		12
13	CNA Training										13
14	Program Transportation		3,602		3,602		3,602		3,602		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,032,648	184,046	300,919	1,517,613		1,517,613	(12,783)	1,504,830		16
	C. General Administration										
17	Administrative	64,833			64,833		64,833		64,833		17
18	Directors Fees										18
19	Professional Services			22,331	22,331		22,331		22,331		19
20	Dues, Fees, Subscriptions & Promotions			32,183	32,183		32,183	(20,293)	11,890		20
21	Clerical & General Office Expenses	57,643	9,959	15,689	83,291		83,291		83,291		21
22	Employee Benefits & Payroll Taxes			222,345	222,345	13,793	236,138		236,138		22
23	Inservice Training & Education			1,316	1,316		1,316		1,316		23
24	Travel and Seminar			2,464	2,464		2,464		2,464		24
25	Other Admin. Staff Transportation		3,602		3,602		3,602		3,602		25
26	Insurance-Prop.Liab.Malpractice			86,434	86,434		86,434		86,434		26
27	Other (specify):* Sales Tax			915	915		915	(915)			27
28	TOTAL General Administration	122,476	13,561	383,677	519,714	13,793	533,507	(21,208)	512,299		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,561,241	372,459	848,421	2,782,121		2,782,121	(41,946)	2,740,175		29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number St Ann's Healthcare Center #0023390 Report Period Beginning: 01-01-2006 Ending: 12-31-2006

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 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			68,714	68,714		68,714	655	69,369		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			82,462	82,462		82,462	(589)	81,873		32
33	Real Estate Taxes			31,530	31,530		31,530		31,530		33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles										35
36	Other (specify):* Bad Debts			42,602	42,602		42,602	(42,602)			36
37	TOTAL Ownership			225,308	225,308		225,308	(42,536)	182,772		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers										39
40	Barber and Beauty Shops			8,865	8,865		8,865		8,865		40
41	Coffee and Gift Shops		10,488		10,488		10,488		10,488		41
42	Provider Participation Fee			65,153	65,153		65,153		65,153		42
43	Other (specify):*										43
44	TOTAL Special Cost Centers		10,488	74,018	84,506		84,506		84,506		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,561,241	382,947	1,147,747	3,091,935		3,091,935	(84,482)	3,007,453		45

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

Facility Name & ID Number St Ann's Healthcare Center

0023390

Report Period Beginning: 01-01-2006

Ending: 12-31-2006

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	(7,955)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients	(12,783)	10		7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(589)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(915)	27		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	(524)	20		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	(42,602)	36		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(19,769)	20		28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (85,137)		\$	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)	655		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 655		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (84,482)		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					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY						
48		49		50		51
						52

St Ann's Healthcare Center

ID# 0023390

Report Period Beginning: 01-01-2006

Ending: 12-31-2006

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number St Ann's Healthcare Center

0023390

Report Period Beginning:

01-01-2006

Ending:

12-31-2006

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	(7,955)	0	0	0	0	0	0	0	0	0	0	(7,955)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(7,955)	0	0	0	0	0	0	0	0	0	0	(7,955)	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	(12,783)	0	0	0	0	0	0	0	0	0	0	(12,783)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(12,783)	0	0	0	0	0	0	0	0	0	0	(12,783)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(20,293)	0	0	0	0	0	0	0	0	0	0	(20,293)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(915)	0	0	0	0	0	0	0	0	0	0	(915)	27
28	TOTAL General Administration	(21,208)	0	0	0	0	0	0	0	0	0	0	(21,208)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(41,946)	0	0	0	0	0	0	0	0	0	0	(41,946)	29

STATE OF ILLINOIS

Facility Name & ID Number St Ann's Healthcare Center

0023390

Report Period Beginning:

01-01-2006 Ending:

Summary B

12-31-2006

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	0	655	0	0	0	0	0	0	0	0	0	655	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(589)	0	0	0	0	0	0	0	0	0	0	(589)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	(42,602)	0	0	0	0	0	0	0	0	0	0	(42,602)	36
37	TOTAL Ownership	(43,191)	655	0	(42,536)	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)	(85,137)	655	0	(84,482)	45								

Facility Name & ID Number St Ann's Healthcare Center

0023390

Report Period Beginning: 01-01-2006 Ending: 12-31-2006

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
Blain Richard	50	ST. Ann's Healthcare	Chester	RDR Management	Hoyleton	MGMT/Leasing
Mike & Gail Greer	50	ST. Ann's Healthcare	Chester	Greer Mgmt	Carlyle	MGMT
Blain Richard	25	Clinton Manor	New Baden			
Mike Greer	25	Clinton Manor	New Baden			

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	30 Depreciation	\$	RDR Management/Leasing		\$ 655	\$ 655	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		\$			\$ 655	\$ * 655	14

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

Facility Name & ID Number St Ann's Healthcare Center # 0023390 Report Period Beginning: 01-01-2006 Ending: 12-31-2006

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	Blain Richard	President	Officer	50.00	St. Ann's	20	50.00		\$	1
2	Mike Greer	Secretary	Officer	50.00	St. Ann's	20	50.00			2
3	Blain Richard	President	RDR Mgmt	100.00		10	25.00			3
4	Mike Greer	President	Greer Mgmt	100.00		10	25.00			4
5										5
6	Blain Richard	President	Clinton Manor	25.00	14,400	4	10.00			6
7	Mike Greer	Secretary	Clinton Manor	25.00	14,400	4	10.00			7
8	Blain Richard	RDR Mgmt	Clinton Manor		24,000	4	10.00			8
9	Mike Greer	Greer Mgmt	Clinton Manor		24,000	4	10.00			9
10										10
11	Blain Richard	RDR Mgmt	So Ill Comm Spt	20.00	16,654	2	5.00			11
12	Mike Greer	Greer Mgmt	So Ill Comm Spt	20.00	16,654	2	5.00			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 St Ann's Healthcare Center

0023390 Report Period Beginning: 01-01-2006 Ending: 2-31-2006

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 _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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					\$	\$		\$	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

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	First National Bnak		X	Mortgage	\$9,556.00	10/15/06	\$ 850,000	\$ 453,338	10/15/09	7.2500	\$ 25,523	1								
2												2								
3												3								
4												4								
5												5								
Working Capital																				
6	Owner Loans	X		Cash Flow		04/01/06	1,755,426	1,755,426	03/31/07	3.0000	41,982	6								
7	Buena Vista		X	Line of Credit	\$1,888.00	01/01/03	192,030	187,747		8.2500	14,957	7								
8												8								
9	TOTAL Facility Related				\$11,444.00		\$ 2,797,456	\$ 2,396,511			\$ 82,462	9								
B. Non-Facility Related*																				
10	Interest Income		X								(589)	10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			(589)	14								
15	TOTALS (line 9+line14)						\$ 2,797,456	\$ 2,396,511			\$ 81,873	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

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>			
1. Real Estate Tax accrual used on 2005 report.		\$ 16,977	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.)		\$ 2005 31530	2
3. Under or (over) accrual (line 2 minus line 1).		\$ 14,553	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 16,977	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.		\$ 31,530	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2001	30,471	8
	2002	30,757	9
	2003	33,028	10
	2004	33,418	11
	2005	31,530	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 St Ann's Healthcare Center COUNTY Randolf

FACILITY IDPH LICENSE NUMBER 0023390

CONTACT PERSON REGARDING THIS REPORT Mike Greer

TELEPHONE 618-826-2314 FAX #: 618-826-5047

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. <u>18-034-011-00</u>	<u>Nursing Home Property</u>	\$ <u>30,986.04</u>	\$ <u>30,986.04</u>
2. <u>18-037-005.00</u>	<u>Nursing Home Property</u>	\$ <u>96.78</u>	\$ <u>96.78</u>
3. <u>18-040-003-00</u>	<u>Nursing Home Property</u>	\$ <u>219.34</u>	\$ <u>219.34</u>
4. <u>18-037-006-00</u>	<u>Nursing Home Property</u>	\$ <u>148.34</u>	\$ <u>148.34</u>
5. <u>18-034-009-00</u>	<u>Nursing Home Property</u>	\$ <u>79.82</u>	\$ <u>79.82</u>
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>31,530.32</u>	\$ <u>31,530.32</u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES 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 St Ann's Healthcare Center

0023390

Report Period Beginning:

01-01-2006 Ending:

12-31-2006

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 50,246 B. General Construction Type: Exterior Brick Frame Wood, Steel, Concrete Number of Stories 2

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).

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>Facility</u>	<u>103,500</u>	<u>1977</u>	<u>\$ 20,000</u>	1
2					2
3	TOTALS	103,500		\$ 20,000	3

Facility Name & ID Number St Ann's Healthcare Center

0023390

Report Period Beginning:

01-01-2006 Ending: 12-31-2006

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	48		1977	1937	\$ 404,102	\$	20	\$	\$	\$ 404,102	4
5	46		1977	1976	250,000	7,327	33	7,327		226,797	5
6	10		1985	1985	104,150	3,171	33	3,171		69,002	6
7	15		1987	1987	344,144	10,417	33	10,417		201,777	7
8			1991	1991	357,704	11,964	30	11,964		179,245	8
Improvement Type**											
9		BUILDING IMP		1978	500		8			500	9
10		NEW ROOF		1983	9,450		15			9,450	10
11		BUILDING IMP		1983	4,469		15			4,469	11
12		ELECTRICAL IMP		1985	3,130		15			3,130	12
13		ROOF REPAIRS		1987	1,830	92	20	92		1,753	13
14		FIRE ALARM		1987	3,900		8			3,900	14
15											15
16		NEW ROOF		1989	4,000		15			4,000	16
17		PARKING LOT		1991	7,708		10			7,708	17
18		BUILDING IMP		1992	12,806	502	20	502		10,254	18
19		TELEPHONE SYSTEM		1992	10,071		10			10,071	19
20		CUBICLE TRACK		1992	6,531		8			6,531	20
21		LAND IMP		1993	1,897	127	15	127		1,663	21
22		A/C UNIT		1984	5,625		8			5,625	22
23		BUILDING IMP		1994	45,734	1,819	20	1,819		32,245	23
24		BUILDING IMP		1993	10,012		10			10,012	24
25		PAINTING		1995	11,460		10			11,460	25
26		ROOF REPAIRS		1995	11,167	561	20	561		6,675	26
27		HANDRAILS		1995	20,700		8			20,700	27
28		BOILER		1995	21,690	1,455	15	1,455		16,234	28
29		ELECTRIAL,FIRE ALARM		1997	12,017	236	8	236		9,598	29
30		NEW ROOF		1999	30,546	1,535	20	1,535		11,643	30
31		NEW ROOF		2000	3,990	266	15	266		1,663	31
32		A/C UNIT		2000	7,265	907	8	907		6,207	32
33		FLOORING		2004	15,971	1,077	15	1,077		2,868	33
34		A/C UNIT		2004	6,378	806	8	806		1,880	34
35		SECURITY ALARM		2004	5,143	644	8	644		1,547	35
36		WASHER		2004	7,887	986	8	986		2,136	36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

Facility Name & ID Number St Ann's Healthcare Center

0023390

Report Period Beginning:

01-01-2006 Ending:

12-31-2006

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 Sign	2006	\$ 5,593	\$ 517	8	\$ 517	\$	\$ 517	37
38 Water Htr	2006	6,479	515	8	515		515	38
39 Ac/Htg unit	2006	13,021	289	15	289		289	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)		\$ 1,767,070	\$ 45,213		\$ 45,213	\$	\$ 1,286,166	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	\$ 185,647	\$ 18,650	\$ 19,305	\$ 655	8	\$ 126,759	71
72	Current Year Purchases	14,316	414	414		8	414	72
73	Fully Depreciated Assets	11,771				8	11,771	73
74								74
75	TOTALS	\$ 211,734	\$ 19,064	\$ 19,719	\$ 655		\$ 138,944	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	Facility	85 Chev Bus	1996	\$ 6,000	\$	\$	\$	3	\$ 6,000	76
77	Facility	96 Dodge Van	2001	4,463	1,116	1,116		3	4,463	77
78	Facility	Van	2001	17,810	3,321	3,321		3	17,810	78
79										79
80	TOTALS			\$ 28,273	\$ 4,437	\$ 4,437	\$		\$ 28,273	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)	\$ 2,027,077	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 68,714	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 69,369	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 655	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,453,383	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	ADM Auto	\$ 27,739	\$	\$ 27,739	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 27,739	\$	\$ 27,739	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 St Ann's Healthcare Center

0023390

Report Period Beginning: 01-01-2006

Ending: 12-31-2006

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					_____			5
6					_____			6
7	TOTAL				\$ _____			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: \$ _____ Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

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.

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

	Service	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	5 Units Cost					
					Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	14

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

Facility Name & ID Number St Ann's Healthcare Center # 0023390 Report Period Beginning: 01-01-2006 Ending: 12-31-2006

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12-31-2006 (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	\$ (78,081)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance (7,343))	1,516,150		3
4	Supply Inventory (priced at <u>FIFO</u>)	33,176		4
5	Short-Term Investments			5
6	Prepaid Insurance	26,299		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,497,544	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	20,000		13
14	Buildings, at Historical Cost	1,687,367		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	319,220		16
17	Accumulated Depreciation (book methods)	(1,452,893)		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):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 573,694	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,071,238	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 80,500	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	64,993		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	1,884		32
33	Accrued Interest Payable	33,448		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 180,825	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,755,426		39
40	Mortgage Payable	453,338		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Line of Credit</u>	187,747		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,396,511	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,577,336	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (506,098)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,071,238	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (421,336)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (421,336)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(84,762)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (84,762)	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)	\$ (506,098)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number St Ann's Healthcare Center# 0023390Report Period Beginning: 01-01-2006Ending: 12-31-2006**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	\$ 2,911,792	1
2	Discounts and Allowances for all Levels	(413,695)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,498,097	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	405,423	6
7	Oxygen	320	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 405,743	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	10,757	12
13	Barber and Beauty Care	9,546	13
14	Non-Patient Meals	7,955	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	59,255	17
18	Sale of Supplies to Non-Patients	12,783	18
19	Laboratory	2,047	19
20	Radiology and X-Ray	400	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 102,743	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	589	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 589	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,007,172	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	744,794	31
32	Health Care	1,517,613	32
33	General Administration	519,714	33
B. Capital Expense			
34	Ownership	225,308	34
C. Ancillary Expense			
35	Special Cost Centers	19,353	35
36	Provider Participation Fee	65,153	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,091,935	40
41	Income before Income Taxes (line 30 minus line 40)**	(84,763)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (84,763)	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 St Ann's Healthcare Center

0023390

Report Period Beginning: 01-01-2006

Ending:

12-31-2006

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	2,095	2,095	\$ 55,562	\$ 26.52	1
2	Assistant Director of Nursing	2,088	2,088	41,725	19.98	2
3	Registered Nurses	5,384	5,680	100,514	17.70	3
4	Licensed Practical Nurses	20,269	21,285	295,435	13.88	4
5	CNAs & Orderlies	46,632	49,488	455,537	9.20	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	4,623	4,679	41,820	8.94	9
10	Activity Assistants	1,206	1,317	8,793	6.68	10
11	Social Service Workers	2,900	2,900	33,262	11.47	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	4,295	4,439	56,335	12.69	15
16	Dishwashers	23,076	24,380	188,246	7.72	16
17	Maintenance Workers	4,134	4,398	47,713	10.85	17
18	Housekeepers	6,314	6,834	59,909	8.77	18
19	Laundry	6,122	6,634	53,914	8.13	19
20	Administrator	878	957	23,833	24.90	20
21	Assistant Administrator					21
22	Other Administrative	2,064	2,088	41,000	19.64	22
23	Office Manager					23
24	Clerical	5,416	5,865	57,643	9.83	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)					33
34	TOTAL (lines 1 - 33)	137,496	145,127	\$ 1,561,241 *	\$ 10.76	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	114	\$ 6,731	1-3	35
36	Medical Director				36
37	Medical Records Consultant	108	2,910	10-3	37
38	Nurse Consultant	30	1,509	10-3	38
39	Pharmacist Consultant	96	1,800	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	48	1,671	11-3	44
45	Social Service Consultant	48	3,827	10-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	444	\$ 18,448		49

C. CONTRACT NURSES

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

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. ILL Healthcare 6021
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? 524
- (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? 8 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 8,567 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 during this cost report period. \$ 65,153
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. \$ 13,793 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 7,955
- (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? 50
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? N
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? N
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.