

		FOR BHF USE					

LL1

2007
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2007)

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

I. IDPH License ID Number: 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 01/01/07 to 12/31/07 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: 01/01/07 Ending: 12/31/07

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	19,606	3,788	16,438	39,832	8
9	SNF/PED					9
10	ICF		19,892		19,892	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	19,606	23,680	16,438	59,724	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.41%

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 10/6/86 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 16,438

Medicare Intermediary Administar Federal

IV. ACCOUNTING BASIS

ACCURAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/07 Fiscal Year: 12/31/07

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

Facility Name & ID Number Provena St Anne Center # 0041731 Report Period Beginning: 01/01/07 Ending: 12/31/07

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 BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	427,384	66,847	31,899	526,130		526,130		526,130		1
2	Food Purchase		365,395		365,395		365,395	4,059	369,454		2
3	Housekeeping	165,325	23,800		189,125		189,125		189,125		3
4	Laundry	1,368	10,203	155,984	167,555		167,555		167,555		4
5	Heat and Other Utilities			207,352	207,352		207,352	2,658	210,010		5
6	Maintenance	142,259	41,000	50,752	234,011		234,011	34,609	268,620		6
7	Other (specify):* Pastoral Care	44,182	1,794	17,544	63,520		63,520	(5,633)	57,887		7
8	TOTAL General Services	780,518	509,039	463,531	1,753,088		1,753,088	35,693	1,788,781		8
	B. Health Care and Programs										
9	Medical Director			20,400	20,400		20,400		20,400		9
10	Nursing and Medical Records	4,509,580	406,867	463,896	5,380,343		5,380,343		5,380,343		10
10a	Therapy			1,302,538	1,302,538		1,302,538		1,302,538		10a
11	Activities	124,352	3,072	8,774	136,198		136,198	829	137,027		11
12	Social Services	118,742			118,742		118,742		118,742		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	4,752,674	409,939	1,795,608	6,958,221		6,958,221	829	6,959,050		16
	C. General Administration										
17	Administrative	400,143	47,061	1,304,640	1,751,844		1,751,844	(357,042)	1,394,802		17
18	Directors Fees										18
19	Professional Services			26,499	26,499		26,499	243,667	270,166		19
20	Dues, Fees, Subscriptions & Promotions			91,043	91,043		91,043	(30,754)	60,289		20
21	Clerical & General Office Expenses			90,207	90,207		90,207	14,453	104,660		21
22	Employee Benefits & Payroll Taxes			1,295,589	1,295,589		1,295,589	152,020	1,447,609		22
23	Inservice Training & Education			12,116	12,116		12,116	6,896	19,012		23
24	Travel and Seminar			18,541	18,541		18,541	9,851	28,392		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			175,560	175,560		175,560	1,818	177,378		26
27	Other (specify):* Bad Debt			726	726		726	(726)			27
28	TOTAL General Administration	400,143	47,061	3,014,921	3,462,125		3,462,125	40,183	3,502,308		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,933,335	966,039	5,274,060	12,173,434		12,173,434	76,705	12,250,139		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: 01/01/07 Ending: 12/31/07

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			346,483	346,483	346,483	183,900	530,383				30
31	Amortization of Pre-Op. & Org.											31
32	Interest						277,023	277,023				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds						23,638	23,638				34
35	Rent-Equipment & Vehicles			19,128	19,128	19,128	3,216	22,344				35
36	Other (specify):*											36
37	TOTAL Ownership			365,611	365,611	365,611	487,777	853,388				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			1,008,746	1,008,746	1,008,746	(346,906)	661,840				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			97,734	97,734	97,734		97,734				42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			1,106,480	1,106,480	1,106,480	(346,906)	759,574				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,933,335	966,039	6,746,151	13,645,525	13,645,525	217,576	13,863,101				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: 01/01/07

Ending: 12/31/07

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	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,742)	2		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	21,557	30		9
10	Interest and Other Investment Income	(13,292)	32		10
11	Discounts, Allowances, Rebates & Refunds	(346,906)	39		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	(726)	27		24
25	Fund Raising, Advertising and Promotional	(43,971)	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)	\$ (385,080)		\$	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)	608,289		34
35	Other- Attach Schedule	(5,633)		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 602,656		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 217,576		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

Provena St Anne Center

ID# 0041731

Report Period Beginning: 01/01/07

Ending: 12/31/07

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Development - Office Supplies	\$ (46)	7	1
2	Development - Miscellaneous	(5,587)	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	(5,633)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Provena St Anne Center

0041731

Report Period Beginning:

01/01/07

Ending:

12/31/07

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	(1,742)	5,801	0	0	0	0	0	0	0	0	0	4,059	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	2,658	0	0	0	0	0	0	0	0	0	2,658	5
6	Maintenance	0	699	33,910	0	0	0	0	0	0	0	0	34,609	6
7	Other (specify):*	(5,633)	0	0	0	0	0	0	0	0	0	0	(5,633)	7
8	TOTAL General Services	(7,375)	9,158	33,910	0	35,693	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	829	0	0	0	0	0	0	0	0	0	829	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	829	0	0	0	0	0	0	0	0	0	829	16
	C. General Administration													
17	Administrative	0	(568,834)	211,792	0	0	0	0	0	0	0	0	(357,042)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	95,803	147,864	0	0	0	0	0	0	0	0	243,667	19
20	Fees, Subscriptions & Promotions	(43,971)	13,217	0	0	0	0	0	0	0	0	0	(30,754)	20
21	Clerical & General Office Expenses	0	14,453	0	0	0	0	0	0	0	0	0	14,453	21
22	Employee Benefits & Payroll Taxes	0	76,938	75,082	0	0	0	0	0	0	0	0	152,020	22
23	Inservice Training & Education	0	6,896	0	0	0	0	0	0	0	0	0	6,896	23
24	Travel and Seminar	0	9,851	0	0	0	0	0	0	0	0	0	9,851	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	1,818	0	0	0	0	0	0	0	0	0	1,818	26
27	Other (specify):*	(726)	0	0	0	0	0	0	0	0	0	0	(726)	27
28	TOTAL General Administration	(44,697)	(349,858)	434,738	0	40,183	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(52,072)	(339,871)	468,648	0	76,705	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Provena St Anne Center

0041731

Report Period Beginning:

01/01/07 Ending:

12/31/07

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	21,557	0	162,343	0	0	0	0	0	0	0	0	183,900	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(13,292)	0	290,315	0	0	0	0	0	0	0	0	277,023	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	23,638	0	0	0	0	0	0	0	0	23,638	34
35	Rent-Equipment & Vehicles	0	0	3,216	0	0	0	0	0	0	0	0	3,216	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	8,265	0	479,512	0	487,777	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	(346,906)	0	0	0	0	0	0	0	0	0	0	(346,906)	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	(346,906)	0	0	0	0	0	0	0	0	0	0	(346,906)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(390,713)	(339,871)	948,160	0	217,576	45							

Facility Name & ID Number Provena St Anne Center

0041731

Report Period Beginning:

01/01/07

Ending:

12/31/07

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%	\$ 5,801	\$ 5,801 1
2	V	5 Utilities		Provena Senior Services	100.00%	2,658	2,658 2
3	V	6 Maintenance - Other		Provena Senior Services	100.00%	699	699 3
4	V	11 Activities-Special Events		Provena Senior Services	100.00%	829	829 4
5	V	17 Admin - Misc. Other	870,840	Provena Senior Services	100.00%	17,368	(853,472) 5
6	V	17 Administrative Services		Provena Senior Services	100.00%	284,638	284,638 6
7	V	19 Professional Salaries		Provena Senior Services	100.00%	95,803	95,803 7
8	V	20 Dues,Subscriptions		Provena Senior Services	100.00%	13,217	13,217 8
9	V	21 Clerical Supplies		Provena Senior Services	100.00%	14,453	14,453 9
10	V	22 Employee Benefits		Provena Senior Services	100.00%	76,938	76,938 10
11	V	23 Education/Conference		Provena Senior Services	100.00%	6,896	6,896 11
12	V	24 Travel		Provena Senior Services	100.00%	9,851	9,851 12
13	V	26 Insurance		Provena Senior Services	100.00%	1,818	1,818 13
14	Total		\$ 870,840			\$ 530,969	\$ * (339,871) 14

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

Facility Name & ID Number Provena St Anne Center# 0041731Report Period Beginning: 01/01/07Ending: 12/31/07

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	100.00%	\$ 5,132	\$ 5,132	15
16	V	32 Interest		Provena Senior Services	100.00%	290,315	290,315	16
17	V	34 Rent - Facility		Provena Senior Services	100.00%	23,638	23,638	17
18	V	35 Rent - Equipment		Provena Senior Services	100.00%	3,216	3,216	18
19	V	17 Admin Salaries	179,160	Provena Health Services	100.00%	143,869	(35,291)	19
20	V	22 Employee Benefits		Provena Health Services	100.00%	33,863	33,863	20
21	V	30 Depreciation		Provena Health Services	100.00%	157,211	157,211	21
22	V	19 Admin Consulting,Other		Provena Health Services	100.00%	147,864	147,864	22
23	V	17 Information Systems Salaries	254,640	Provena Health Services	100.00%	48,998	(205,642)	23
24	V	22 Information Systems Benefits		Provena Health Services	100.00%	11,236	11,236	24
25	V	17 Information Systems - Other		Provena Health Services	100.00%	325,345	325,345	25
26	V	17 Admin Salaries		Provena Health Services	100.00%	68,472	68,472	26
27	V	22 Employee Benefits		Provena Health Services	100.00%	16,117	16,117	27
28	V	17 Information Systems Salaries		Provena Health Services	100.00%	58,908	58,908	28
29	V	22 Information Systems Benefits		Provena Health Services	100.00%	13,866	13,866	29
30	V	6 Information Systems - Equip Maint		Provena Health Services	100.00%	33,910	33,910	30
31	V	39 Ancillary Services - Other	1,008,746	Provena Senior Services Pharmacy	100.00%	1,008,746		31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 1,442,546			\$ 2,390,706	\$ * 948,160	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:

01/01/07

Ending:

12/31/07

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:

01/01/07

Ending: 12/31/07

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 6,620,619	19	\$ 44,100	\$	870,840	\$ 5,801	1
2	5	Utilities	Management Fee Income 6,620,619	19	20,208		870,840	2,658	2
3	6	Maintenance - Other	Management Fee Income 6,620,619	19	5,313		870,840	699	3
4	11	Activities-Special Events	Management Fee Income 6,620,619	19	6,306		870,840	829	4
5	17	Admin - Misc. Other	Management Fee Income 6,620,619	19	132,045		870,840	17,368	5
6	17	Administrative Salaries	Management Fee Income 6,620,619	19	2,163,976	2,163,976	870,840	284,638	6
7	19	Professional Services	Management Fee Income 6,620,619	19	728,345		870,840	95,803	7
8	20	Dues,Subscriptions	Management Fee Income 6,620,619	19	100,486		870,840	13,217	8
9	21	Clerical Supplies	Management Fee Income 6,620,619	19	109,877		870,840	14,453	9
10	22	Employee Benefits	Management Fee Income 6,620,619	19	584,930		870,840	76,938	10
11	23	Education/Conference	Management Fee Income 6,620,619	19	52,430		870,840	6,896	11
12	24	Travel	Management Fee Income 6,620,619	19	74,891		870,840	9,851	12
13	26	Insurance	Management Fee Income 6,620,619	19	13,824		870,840	1,818	13
14	30	Depreciation	Management Fee Income 6,620,619	19	39,013		870,840	5,132	14
15	32	Interest	Management Fee Income 6,620,619	19	2,207,136		870,840	290,315	15
16	34	Rent - Facility	Management Fee Income 6,620,619	19	179,713		870,840	23,638	16
17	35	Rent - Equipment	Management Fee Income 6,620,619	19	24,448		870,840	3,216	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 6,487,041	\$ 2,163,976		\$ 853,270	25

Facility Name & ID Number Provena St Anne Center

0041731

Report Period Beginning:

01/01/07

Ending: 12/31/07

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	1,239,804	10	\$ 995,585	\$ 995,585	179,160	\$ 143,869	1
2	22	Employee Benefits	Operating Expense	1,239,804	10	234,337		179,160	33,863	2
3	30	Depreciation	Operating Expense	1,239,804	10	1,087,913		179,160	157,211	3
4	19	Admin Consulting,Other	Operating Expense	1,239,804	10	1,023,231		179,160	147,864	4
5	17	Information Systems Salaries	Operating Expense	1,759,764	10	338,615	338,615	254,640	48,998	5
6	22	Information Systems Benefits	Operating Expense	1,759,764	10	77,649		254,640	11,236	6
7	17	Information Systems - Other	Operating Expense	1,759,764	10	2,248,393		254,640	325,345	7
8	17	Admin Salaries	Direct Cost	1,239,804	10	473,834	473,834	179,160	68,472	8
9	22	Employee Benefits	Direct Cost	1,239,804	10	111,529		179,160	16,117	9
10	17	Information Systems Salaries	Direct Cost	1,759,764	10	407,099	407,099	254,640	58,908	10
11	22	Information Systems Benefits	Direct Cost	1,759,764	10	95,822		254,640	13,866	11
12	6	Information Systems - Equip Main	Direct Cost	1,759,764	10	234,347		254,640	33,910	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					\$ 7,328,354	\$ 2,215,133		\$ 1,059,659	25

Facility Name & ID Number Provena St Anne Center

0041731

Report Period Beginning: 01/01/07

Ending: 12/31/07

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		\$	\$		\$ 1,008,746	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				\$	\$		\$ 1,008,746	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	Home Office Allocation									\$ 290,315	1									
2											2									
3											3									
4											4									
5											5									
Working Capital																				
6											6									
7											7									
8											8									
9	TOTAL Facility Related					\$	\$			\$ 290,315	9									
B. Non-Facility Related*																				
10	Provena Senior Services										10									
11											11									
12											12									
13											13									
14	TOTAL Non-Facility Related					\$	\$			\$	14									
15	TOTALS (line 9+line14)					\$	\$			\$ 290,315	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 2006 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 2007 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:					
2002	_____	8			
2003	_____	9			
2004	_____	10			
2005	_____	11			
2006	_____	12			
			FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2006	\$		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:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

2006 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 2006 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 2006.

(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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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:

01/01/07 Ending:

12/31/07

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).

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>\$ 639,976</u>	1
2					2
3	TOTALS			\$ 639,976	3

Facility Name & ID Number Provena St Anne Center

0041731

Report Period Beginning:

01/01/07

Ending:

12/31/07

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	1986	\$ 3,516,907	\$ 100,483	35	\$ 100,483		\$ 2,238,764	4
5	59		1993	1993	2,722,251	90,742	30	90,742		1,307,447	5
6											6
7											7
8											8
Improvement Type**											
9	Various			1990	36,166	1,122	17	1,122		21,018	9
10	Various			1991	22,363		10			22,363	10
11	Various			1992	471		10			471	11
12	Various			1993	3,828		10			3,828	12
13	Various			1994	5,000		10			5,000	13
14	Various			1995	40,225	1,271	18	1,271		23,280	14
15	Various			1996	28,449	1,621	12	1,621		22,562	15
16	Various			1997	27,832	118	5	118		27,832	16
17	Various			1998	27,020		5			27,020	17
18	Various			1999	7,187	60	5	60		7,097	18
19	Various			2000	34,790	571	5	571		33,362	19
20	Various			2001	284,002	18,849	6	18,849		154,749	20
21	Various			2002	13,716	1,507	10	1,507		8,549	21
22	Various			2003	34,755	3,326	9	3,326		14,967	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:

01/01/07

Ending:

12/31/07

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	ROOF REPAIR	2004	\$ 18,000	\$ 1,800	10	\$ 1,800	\$	\$ 6,300	37
38	REPLACE WATER HEATER IN	2004	6,700	670	10	670		2,345	38
39	STRIP AND REAPPLY NEW WA	2004	3,810	762	5	762		2,667	39
40	WATER VALVES	2004	2,200	147	15	147		513	40
41	INSTALLATION OF AMPLIFIE	2004	2,041	204	10	204		714	41
42	SEAL AND STRIPE PARKING	2004	1,970	197	10	197		690	42
43	GENERATOR HOSES & BOLTS,	2004	1,911	382	5	382		1,337	43
44	FLAT ROOF REPAIR	2004	1,350	135	10	135		473	44
45	CARPET INSTALLATION AND	2004	985	394	5	394		985	45
46	CATERPILLAR GENERATOR AN	2004	807		1			807	46
47	COMMERCIAL CEILING CLEAN	2004	575	115	5	115		460	47
48									48
49	3 CRANK HURD WINDOWS	2005	5,745	575	10	575		1,436	49
50	WATER HEATER ON LOWER LE	2005	5,330	533	10	533		1,599	50
51	GENERATOR- FLUSH COOLING	2005	3,112	622	5	622		1,867	51
52	DEMOLITION & DRYWALL	2005	2,841	284	10	284		710	52
53	REPLACE AIR COMPRESSOR	2005	1,984	165	12	165		413	53
54	DOOR CLOSURES	2005	1,772	177	10	177		443	54
55	REPAIR BROKEN SPRINKLER	2005	1,530	306	5	306		765	55
56	H/M DOORS AND FRAMES	2005	1,481	74	20	74		185	56
57	REPLACE BREATHER, HOSES,	2005	1,462	209	7	209		522	57
58	REPLACE RADIATOR BELTS /	2005	1,200	240	5	240		720	58
59	4'X6' ALUMINUM FRAMED MA	2005	785	79	10	79		196	59
60	V14 SOLAR PROTECTIVE FIL	2005	598	120	5	120		299	60
61	V14 SOLAR PROTECTIVE FIL	2005	582	58	10	58		146	61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 6,873,732	\$ 227,918		\$ 227,918	\$	\$ 3,944,902	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:

01/01/07

Ending:

12/31/07

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		\$ 6,873,732	\$ 227,918		\$ 227,918	\$	\$ 3,944,902	1
2	WALK IN COOLER AND FREEZ	2006	30,100	2,007	15	2,007		3,010	2
3	TEKNOFLOR/VINYL BASE IN	2006	22,100	2,210	10	2,210		3,315	3
4	REPLACE ROOF MOUNT MUA U	2006	9,935	662	15	662		1,325	4
5	CARPET IN 8 PATIENT ROOM	2006	7,640	1,528	5	1,528		2,292	5
6	REMOVE & REPAIR WATER DA	2006	4,730	473	10	473		710	6
7	VINYL SIDING ON GARAGE A	2006	4,365	291	15	291		437	7
8	ELECTRICAL FOR NEW KITCH	2006	4,279	285	15	285		571	8
9	REPLACE CEILING TILES IN	2006	4,000	400	10	400		600	9
10	PLUMBING FOR NEW BREAK R	2006	2,950	148	20	148		295	10
11	RUB RAILS	2006	2,051	205	10	205		308	11
12	REPLACE PIPING	2006	1,359	91	15	91		136	12
13	OPEN CEILING FOR SPRINKL	2006	1,000	200	5	200		300	13
14	HOLLOW METAL FRAMES AND	2006	585	29	20	29		44	14
15	V14 SOLAR PROTECTIVE FIM	2006	555	111	5	111		222	15
16									16
17	REPLACE FIRE SPRINKLER M	2007	63,980	3,199	10	6,398	3,199	3,199	17
18	INSTALL ACOUSTICAL CEILI	2007	36,500	1,825	10	3,650	1,825	1,825	18
19	CABINETS AND COUNTERTOPS	2007	12,516	417	15	834	417	417	19
20	REMODEL OF MAIN NURSES S	2007	12,500	417	15	833	417	417	20
21	10 TON ROOFTOP UNIT WITH	2007	11,889	396	15	793	396	396	21
22	PAINTING ROOMS AND HALLW	2007	9,922	1,984	5	3,969	1,984	1,984	22
23	ELECTRICAL WORK	2007	9,609	480	10	961	480	480	23
24	VINYL FLOORING & CARPET	2007	8,366	418	10	837	418	418	24
25	(19) SUPPLY/RETURN GRILL	2007	3,280	234	7	469	234	234	25
26	SPRINKLER SYSTEM / CONCR	2007	750	15	25	30	15	15	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,138,694	\$ 245,944		\$ 255,331	\$ 9,387	\$ 3,967,851	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: 01/01/07 Ending: 12/31/07

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	\$ 844,974	\$ 88,369	\$ 88,369	\$	10	\$ 273,714	71
72	Current Year Purchases	177,849	12,170	24,340	12,170	9	12,170	72
73	Fully Depreciated Assets	547,228				7	540,889	73
74	Home Office Allocation		162,343	162,343				74
75	TOTALS	\$ 1,570,051	\$ 262,882	\$ 275,052	\$ 12,170		\$ 826,773	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	Plant Engineering	1998 Minivan	1998	\$ 43,500	\$	\$	\$	5	\$ 43,500	76
77	Plant Engineering	1999 F150 Ford Truck	1999	23,172				3	23,172	77
78										78
79										79
80	TOTALS			\$ 66,672	\$	\$	\$		\$ 66,672	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)	\$ 9,415,393	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 508,826	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 530,383	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 21,557	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,861,296	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: 01/01/07

Ending: 12/31/07

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				23,638			5
6					_____			6
7	TOTAL				\$ 23,638			7

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

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

9. Option to Buy: YES NO Terms: _____*

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

15. Is Movable equipment rental included in building rental? _____

YES NO

16. Rental Amount for movable equipment: \$ 310,881 Description: Nursing \$281708, Activities \$149, Plant Eng. \$6680, Admin. \$19128. Home Office \$3216

(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

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. _____/2008 \$ _____

13. _____/2009 \$ _____

14. _____/2010 \$ _____

* 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	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	\$	10,867	\$ 586,818	\$	10,867	\$ 586,818	1
2	Licensed Speech and Language Development Therapist	10a, 3	hrs		1,409	76,082		1,409	76,082	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a, 3	hrs		11,845	639,638		11,845	639,638	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39, 3	# of prescrpts				1,008,746		1,008,746	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			\$	24,121	\$ 1,302,538	\$ 1,008,746	24,121	\$ 2,311,284	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: 01/01/07

Ending:

12/31/07

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/07

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 8,785,520	\$	1
2	Cash-Patient Deposits	113,303		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	11,176,143		3
4	Supply Inventory (priced at)	533,002		4
5	Short-Term Investments			5
6	Prepaid Insurance	16,312		6
7	Other Prepaid Expenses	134,911		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 20,759,191	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	7,331,517		12
13	Land	6,751,685		13
14	Buildings, at Historical Cost	83,408,867		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	18,112,162		16
17	Accumulated Depreciation (book methods)	(49,944,144)		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>	120,120		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 65,780,207	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 86,539,398	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 4,826,767	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,861,673		28
29	Short-Term Notes Payable	42,163		29
30	Accrued Salaries Payable	2,756,052		30
31	Accrued Taxes Payable (excluding real estate taxes)	80,845		31
32	Accrued Real Estate Taxes(Sch.IX-B)	823,060		32
33	Accrued Interest Payable	41,064		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Due to Related Party</u>	817,281		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 11,248,905	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,247,620		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	338,908		42
	Other Long-Term Liabilities(specify):			
43	<u>Conditional Asset Retirement</u>	450,209		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,036,737	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 13,285,642	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 73,253,756	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 86,539,398	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 73,502,583	1
2	Restatements (describe):		2
3	Transfer to Affiliates	(2,361,850)	3
4	Adj. To reconcile consolidated equity & consolidated income	1,917,637	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 73,058,370	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	312,058	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock	(333,474)	9
10	Stock Options Exercised		10
11	Contributions and Grants	417,345	11
12	Expenditures for Specific Purposes	(200,543)	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)	\$ 195,386	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)	\$ 73,253,756	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Provena St Anne Center# 0041731Report Period Beginning: 01/01/07Ending: 12/31/07**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	\$ 10,215,190	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 10,215,190	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,247,134	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,247,134	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	6,985	13
14	Non-Patient Meals	1,742	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	928,321	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	7,500	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 944,548	23
D. Non-Operating Revenue			
24	Contributions	110,525	24
25	Interest and Other Investment Income***	13,292	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 123,817	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Purchase Rebates</u>	346,906	28
28a	<u>Misc. Income</u>	87,604	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 434,510	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 13,965,199	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,753,088	31
32	Health Care	6,958,221	32
33	General Administration	3,462,126	33
B. Capital Expense			
34	Ownership	365,610	34
C. Ancillary Expense			
35	Special Cost Centers	1,008,746	35
36	Provider Participation Fee	97,734	36
D. Other Expenses (specify):			
37	<u>Loss on SOFA</u>	7,616	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 13,653,141	40
41	Income before Income Taxes (line 30 minus line 40)**	312,058	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 312,058	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:

01/01/07

Ending:

12/31/07

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	1,760	1,856	\$ 68,885	\$ 37.11	1
2	Assistant Director of Nursing	1,992	2,080	66,472	31.96	2
3	Registered Nurses	22,580	24,097	713,897	29.63	3
4	Licensed Practical Nurses	64,915	69,579	1,497,663	21.52	4
5	CNAs & Orderlies	155,146	166,486	2,162,663	12.99	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,760	2,063	33,490	16.23	9
10	Activity Assistants	8,092	8,724	90,862	10.42	10
11	Social Service Workers	6,904	7,496	118,742	15.84	11
12	Dietician	1,928	2,080	43,935	21.12	12
13	Food Service Supervisor	2,845	3,149	48,823	15.50	13
14	Head Cook	19	19	196	10.32	14
15	Cook Helpers/Assistants	33,840	35,705	334,430	9.37	15
16	Dishwashers					16
17	Maintenance Workers	8,124	8,632	142,258	16.48	17
18	Housekeepers	18,019	19,165	165,325	8.63	18
19	Laundry	162	162	1,368	8.44	19
20	Administrator	1,840	2,080	94,527	45.45	20
21	Assistant Administrator	1,736	1,880	46,382	24.67	21
22	Other Administrative	3,898	4,166	96,792	23.23	22
23	Office Manager	1,896	2,080	37,606	18.08	23
24	Clerical	8,566	9,268	124,836	13.47	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>	2,101	2,422	44,182	18.24	33
34	TOTAL (lines 1 - 33)	348,123	373,189	\$ 5,933,334 *	\$ 15.90	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	429	\$ 31,033	1,3	35
36	Medical Director	\$1700/mo	20,400	9,3	36
37	Medical Records Consultant	24	1,028	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	40	2,160	11,3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	493	\$ 54,621		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	1,258	\$ 54,081	10,3	50
51	Licensed Practical Nurses	3,084	107,938	10,3	51
52	Certified Nurse Assistants/Aides	275	6,611	10,3	52
53	TOTAL (lines 50 - 52)	4,617	\$ 168,630		53

Facility Name & ID Number Provena St Anne Center

0041731

Report Period Beginning: 01/01/07

Ending: 12/31/07

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	\$ 94,527	Workers' Compensation Insurance	\$ 170,160	IDPH License Fee	\$	
Administrative Staff	Asst Administrator	0	46,382	Unemployment Compensation Insurance	33,336	Advertising: Employee Recruitment		
Administrative Staff	Office Manager	0	37,606	FICA Taxes	427,417	Health Care Worker Background Check		
Administrative Staff	Human Resources	0	38,557	Employee Health Insurance	430,721	(Indicate # of checks performed <u>143</u>)		
Administrative Staff	Receptionist	0	53,318	Employee Meals		Patient Background Checks	<u>586</u>	
Administrative Staff	Admin Asst	0	32,961	Illinois Municipal Retirement Fund (IMRF)*		Employee Recruitment	32,134	
Administrative Staff	Admissions	0	96,792	Life Insurance	29,710	Dues & Subscription	12,133	
TOTAL (agree to Schedule V, line 17, col. 1)				Pension	166,063	Advertising & Public Relations	46,776	
(List each licensed administrator separately.)			\$ 400,143	Employee Recognition	2,669			
B. Administrative - Other				Executive Benefits	7,008	Home Office Allocation	13,217	
Description			Amount	Employee Screening	28,505	Less: Public Relations Expense	()	
Corp Service Fee			\$ 179,160	Home Office Allocation	152,020	Non-allowable advertising	(43,971)	
Corp Service IS Fee			254,640			Yellow page advertising	()	
Mgmt Fee			644,040	TOTAL (agree to Schedule V, line 22, col.8)			\$ 1,447,609	
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)			\$ 1,304,640	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		\$ 850	Out-of-State Travel			\$ 2,114	
Survey & Analytical Tools	Various		9,213					
Transportation Service	Various		5,188	In-State Travel			16,427	
Gift Shop	Various		7,800					
Shredding	Various		895	Seminar Expense				
Living Design	Various		1,595					
Outsourced Services	Various		958	Home Office Allocation			9,851	
				Entertainment Expense			()	
				(agree to Sch. V, line 24, col. 8)				
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			\$ 28,392	
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 26,499					

* Attach copy of IMRF notifications

**See instructions.

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. Life Service Network \$8,223
- (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. \$ 75,488 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. \$ 97,734
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? Yes
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.