



Facility Name & ID Number St Ann's Healthcare Center# 0023390 Report Period Beginning: 01-01-08 Ending: 12-31-08

## 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>11,712</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>87</u>	Intermediate (ICF)	<u>87</u>	<u>31,842</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>43,554</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>1,436</u>	<u>2,907</u>	<u>4,343</u>	8
9	SNF/PED					9
10	ICF	<u>10,616</u>	<u>7,938</u>		<u>18,554</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>10,616</u>	<u>9,374</u>	<u>2,907</u>	<u>22,897</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 52.57%

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)

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

G. Do pages 3 &amp; 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 03-01-1977

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 2,907Medicare Intermediary Wisconsin Physicians Service Insurance Corporation

## IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\* Is your fiscal year identical to your tax year? YES  NO Tax Year: 2008 Fiscal Year: 2008

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

Facility Name & ID Number St Ann's Healthcare Center # 0023390 Report Period Beginning: 01-01-08 Ending: 12-31-08

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
	<b>A. General Services</b>										
1	Dietary	187,258	13,886	7,235	208,379		208,379	208,379			1
2	Food Purchase		124,286		124,286	(7,100)	117,186	(6,686)	110,500		2
3	Housekeeping	59,096	18,460	840	78,396		78,396	78,396			3
4	Laundry	60,751	6,957		67,708		67,708	67,708			4
5	Heat and Other Utilities			120,626	120,626		120,626	120,626			5
6	Maintenance	44,934	22,732	54,746	122,412		122,412	122,412			6
7	Other (specify):* Sales Tax			520	520		520	(520)			7
8	<b>TOTAL General Services</b>	<b>352,039</b>	<b>186,321</b>	<b>183,967</b>	<b>722,327</b>	<b>(7,100)</b>	<b>715,227</b>	<b>(7,206)</b>	<b>708,021</b>		8
	<b>B. Health Care and Programs</b>										
9	Medical Director										9
10	Nursing and Medical Records	867,549	159,557	4,599	1,031,705		1,031,705	1,031,705			10
10a	Therapy			231,695	231,695		231,695	231,695			10a
11	Activities	42,804	9,816	1,938	54,558		54,558	54,558			11
12	Social Services	25,469	699	3,314	29,482		29,482	29,482			12
13	CNA Training										13
14	Program Transportation		7,285		7,285		7,285	7,285			14
15	Other (specify):* Penalty			12,424	12,424		12,424	(12,424)			15
16	<b>TOTAL Health Care and Programs</b>	<b>935,822</b>	<b>177,357</b>	<b>253,970</b>	<b>1,367,149</b>		<b>1,367,149</b>	<b>(12,424)</b>	<b>1,354,725</b>		16
	<b>C. General Administration</b>										
17	Administrative	52,445			52,445		52,445	52,445			17
18	Directors Fees										18
19	Professional Services			174,335	174,335	(150)	174,185	(122,000)	52,185		19
20	Dues, Fees, Subscriptions & Promotions			26,446	26,446	150	26,596	(21,501)	5,095		20
21	Clerical & General Office Expenses	49,358	20,050	13,350	82,758		82,758	82,758			21
22	Employee Benefits & Payroll Taxes			233,573	233,573	7,100	240,673	240,673			22
23	Inservice Training & Education			286	286		286	286			23
24	Travel and Seminar			3,150	3,150		3,150	3,150			24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			75,637	75,637		75,637	75,637			26
27	Other (specify):* Bad Debts			55,589	55,589		55,589	(55,589)			27
28	<b>TOTAL General Administration</b>	<b>101,803</b>	<b>20,050</b>	<b>582,366</b>	<b>704,219</b>	<b>7,100</b>	<b>711,319</b>	<b>(199,090)</b>	<b>512,229</b>		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>1,389,664</b>	<b>383,728</b>	<b>1,020,303</b>	<b>2,793,695</b>		<b>2,793,695</b>	<b>(218,720)</b>	<b>2,574,975</b>		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: 01-01-08 Ending: 12-31-08

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 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
	<b>D. Ownership</b>										
30	Depreciation			65,667	65,667		65,667		65,667		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			102,625	102,625		102,625	(1,811)	100,814		32
33	Real Estate Taxes			32,546	32,546		32,546		32,546		33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles										35
36	Other (specify):*										36
37	<b>TOTAL Ownership</b>			200,838	200,838		200,838	(1,811)	199,027		37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers			952	952		952		952		39
40	Barber and Beauty Shops			7,318	7,318		7,318		7,318		40
41	Coffee and Gift Shops		13,760		13,760		13,760	(13,760)			41
42	Provider Participation Fee			65,332	65,332		65,332		65,332		42
43	Other (specify):*										43
44	<b>TOTAL Special Cost Centers</b>		13,760	73,602	87,362		87,362	(13,760)	73,602		44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,389,664	397,488	1,294,743	3,081,895		3,081,895	(234,291)	2,847,604		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: 01-01-08

Ending: 12-31-08

**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	(6,327)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients	(13,760)	41		7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(1,811)	32		10
11	Discounts, Allowances, Rebates & Refunds	(359)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(520)	7		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	(12,424)	15		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	(55,589)	27		24
25	Fund Raising, Advertising and Promotional	(21,501)	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	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (112,291)		\$	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)	(122,000)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (122,000)		36
37	<b>TOTAL ADJUSTMENTS (A) and (B) (sum of SUBTOTALS)</b>	\$ (234,291)		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						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY						
48		49		50		51
						52

St Ann's Healthcare Center

ID# 0023390

Report Period Beginning: 01-01-08

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Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	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	<b>Total</b>	0	49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number St Ann's Healthcare Center

# 0023390

Report Period Beginning:

01-01-08

Ending:

12-31-08

## 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)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(6,686)	0	0	0	0	0	0	0	0	0	0	(6,686)	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):*	(520)	0	0	0	0	0	0	0	0	0	0	(520)	7
8	<b>TOTAL General Services</b>	<b>(7,206)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(7,206)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	(12,424)	0	0	0	0	0	0	0	0	0	0	(12,424)	15
16	<b>TOTAL Health Care and Programs</b>	<b>(12,424)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(12,424)</b>	<b>16</b>
	<b>C. General Administration</b>													
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	(122,000)	0	0	0	0	0	0	0	0	0	(122,000)	19
20	Fees, Subscriptions & Promotions	(21,501)	0	0	0	0	0	0	0	0	0	0	(21,501)	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):*	(55,589)	0	0	0	0	0	0	0	0	0	0	(55,589)	27
28	<b>TOTAL General Administration</b>	<b>(77,090)</b>	<b>(122,000)</b>	<b>0</b>	<b>(199,090)</b>	<b>28</b>								
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(96,720)</b>	<b>(122,000)</b>	<b>0</b>	<b>(218,720)</b>	<b>29</b>								

STATE OF ILLINOIS

Facility Name & ID Number St Ann's Healthcare Center

# 0023390

Report Period Beginning:

01-01-08 Ending:

Summary B

12-31-08

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	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,811)	0	0	0	0	0	0	0	0	0	0	(1,811)	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):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(1,811)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(1,811)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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	(13,760)	0	0	0	0	0	0	0	0	0	0	(13,760)	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	<b>TOTAL Special Cost Centers</b>	<b>(13,760)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(13,760)</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(112,291)</b>	<b>(122,000)</b>	<b>0</b>	<b>(234,291)</b>	<b>45</b>								

Facility Name & ID Number St Ann's Healthcare Center

# 0023390

Report Period Beginning:

01-01-08

Ending:

12-31-08

**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 Healthcrae	Chester	RDR Mgmt	Hoyleton	Management
Mike Greer	25	St. Ann's Healthcrae	Chester	Greer Mgmt	Carlyle	Management
Gail Greer	25	St. Ann's Healthcrae	Chester	Manor at Craig Farm	Chester	Supportive Lvg
Blain Richard	25	Clinton Manor	New Baden			
Mike Greer	12.5	Clinton Manor	New Baden			
Gail Greer	12.5	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	19 Management	\$ 61,000	Greer Management		\$	\$ (61,000)	1
2	V	19 Management	61,000	RDR management			(61,000)	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		\$ 122,000			\$	\$ * (122,000)	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: 01-01-08 Ending: 12-31-08

## 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			\$	1
2	Mike Greer	Secretary	Officer	25.00	St. Ann's	20				2
3	Gail Greer		Director	25.00	St. Ann's					3
4	Blain Richard	President	RDR Mgmt	100.00		10				4
5	Mike Greer	President	Greer Mgmt	100.00		10				5
6	Blain Richard	President	Clinton Manor	25.00	17,800	4				6
7	Mike Greer	Secretary	Clinton Manor	12.50	13,525	4				7
8	Gail Greer	Director	Clinton Manor	12.50	4,275					8
9	Blain Richard	RDR Mgmt	Clinton Manor		33,000	4				9
10	Mike Greer	Greer Mgmt	Clinton Manor		33,000	4				10
11	Blain Richard	RDR Mgmt	So Ill Comm Sup		15,853	2				11
12	Mike Greer	Greer Mgmt	So Ill Comm Sup		15,853	2				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:

01-01-08

Ending: 12-31-08

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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	First National Bank		X	Mortgage	\$3,547.36	09/15/08	\$ 850,000	\$ 305,546	09/15/11	6.5000	\$ 29,502	1								
2												2								
3												3								
4												4								
5												5								
<b>Working Capital</b>																				
6	Owner Loans	X		Cash Flow		04/01/08	1,888,340	1,888,340	03/31/09	3.0000	56,336	6								
7	Buena Vista Bank		X	2nd Mortgage	\$5,153.00	11/18/08	673,815	672,156	11/18/11	6.2500	15,827	7								
8	Fifth Third bank		X	Auto loan	\$566.76	10/12/07	18,605	11,754	10/23/10	6.0000	960	8								
9	<b>TOTAL Facility Related</b>				\$9,267.12		\$ 3,430,760	\$ 2,877,796			\$ 102,625	9								
<b>B. Non-Facility Related*</b>																				
10	Interest Income		X								(1,811)	10								
11												11								
12												12								
13												13								
14	<b>TOTAL Non-Facility Related</b>						\$	\$			(1,811)	14								
15	<b>TOTALS (line 9+line14)</b>						\$ 3,430,760	\$ 2,877,796			\$ 100,814	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><b>Important</b>, 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 2007 report.		\$ <b>16,977</b>	<b>1</b>																																	
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.)		\$ <b>2007 32546</b>	<b>2</b>																																	
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>3</b>																																	
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ <b>1,885</b>	<b>4</b>																																	
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	<b>5</b>																																	
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	<b>6</b>																																	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ <b>32,546</b>	<b>7</b>																																	
Real Estate Tax History:																																				
Real Estate Tax Bill for Calendar Year:	<table border="1"> <tr><td>2003</td><td><b>33,028</b></td><td><b>8</b></td></tr> <tr><td>2004</td><td><b>33,418</b></td><td><b>9</b></td></tr> <tr><td>2005</td><td><b>31,530</b></td><td><b>10</b></td></tr> <tr><td>2006</td><td><b>32,334</b></td><td><b>11</b></td></tr> <tr><td>2007</td><td><b>32,546</b></td><td><b>12</b></td></tr> </table>	2003	<b>33,028</b>	<b>8</b>	2004	<b>33,418</b>	<b>9</b>	2005	<b>31,530</b>	<b>10</b>	2006	<b>32,334</b>	<b>11</b>	2007	<b>32,546</b>	<b>12</b>	<table border="1"> <tr><td colspan="2"><b>FOR BHF USE ONLY</b></td><td></td></tr> <tr><td><b>13</b></td><td>FROM R. E. TAX STATEMENT FOR 2007</td><td>\$</td><td><b>13</b></td></tr> <tr><td><b>14</b></td><td>PLUS APPEAL COST FROM LINE 5</td><td>\$</td><td><b>14</b></td></tr> <tr><td><b>15</b></td><td>LESS REFUND FROM LINE 6</td><td>\$</td><td><b>15</b></td></tr> <tr><td><b>16</b></td><td>AMOUNT TO USE FOR RATE CALCULATION</td><td>\$</td><td><b>16</b></td></tr> </table>	<b>FOR BHF USE ONLY</b>			<b>13</b>	FROM R. E. TAX STATEMENT FOR 2007	\$	<b>13</b>	<b>14</b>	PLUS APPEAL COST FROM LINE 5	\$	<b>14</b>	<b>15</b>	LESS REFUND FROM LINE 6	\$	<b>15</b>	<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION	\$	<b>16</b>
2003	<b>33,028</b>	<b>8</b>																																		
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<b>FOR BHF USE ONLY</b>																																				
<b>13</b>	FROM R. E. TAX STATEMENT FOR 2007	\$	<b>13</b>																																	
<b>14</b>	PLUS APPEAL COST FROM LINE 5	\$	<b>14</b>																																	
<b>15</b>	LESS REFUND FROM LINE 6	\$	<b>15</b>																																	
<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION	\$	<b>16</b>																																	

**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:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

**2007 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 #: 618-826-2316

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

Enter the tax index number and real estate tax assessed for 2007 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 2007.

(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>31,984.48</u>	\$ <u>31,984.48</u>
2. <u>18-037-005-00</u>	<u>Nursing Home Property</u>	\$ <u>99.88</u>	\$ <u>99.88</u>
3. <u>18-040-003-00</u>	<u>Nursing Home Property</u>	\$ <u>226.26</u>	\$ <u>226.26</u>
4. <u>18-037-006-00</u>	<u>Nursing Home Property</u>	\$ <u>153.24</u>	\$ <u>153.24</u>
5. <u>18-034-009-00</u>	<u>Nursing Home Property</u>	\$ <u>82.34</u>	\$ <u>82.34</u>
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>32,546.20</u>	\$ <u>32,546.20</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 X 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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

**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:

01-01-08 Ending:

12-31-08

**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).

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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	<b>TOTALS</b>	<b>103,500</b>		<b>\$ 20,000</b>	<b>3</b>

Facility Name &amp; ID Number St Ann's Healthcare Center

# 0023390

Report Period Beginning:

01-01-08

Ending:

12-31-08

**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		241,451	5
6	10		1985	1985	104,150	3,171	33	3,171		75,345	6
7	15		1897	1987	344,144	10,417	33	10,417		222,611	7
8			1991	1991	357,704	11,964	33	11,964		203,172	8
<b>Improvement Type**</b>											
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		20			1,830	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		11,257	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	106	15	106		1,897	21
22		A/C UNIT		1984	5,625		8			5,625	22
23		BUILDING IMP		1994	45,734	1,819	20	1,819		35,882	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		4,332	26
27		HANDRAILS		1995	20,700		8			20,700	27
28		BOILER		1995	21,690	1,455	15	1,455		19,143	28
29		ELECTRIAL,FIRE ALARM		1997	12,017	236	8	236		10,071	29
30		NEW ROOF		1999	30,546	1,535	20	1,535		14,713	30
31		NEW ROOF		2000	3,990	266	15	266		2,195	31
32		A/C UNIT		2000	7,265	151	8	151		7,265	32
33		FLOORING		2004	15,971	1,077	15	1,077		5,022	33
34		A/C UNIT		2004	6,378	806	8	806		3,491	34
35		SECURITY ALARM		2004	5,143	644	8	644		2,836	35
36		WASHER		2004	7,887	986	8	986		4,108	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:

01-01-08

Ending:

12-31-08

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	\$ 717	8	\$ 717	\$	\$ 1,950	37
38 Water Htr	2006	6,479	823	8	823		2,160	38
39 AC/HTR unit	2006	13,021	868	8	868		2,026	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	\$ 45,431		\$ 45,431	\$	\$ 1,374,415	70

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

Facility Name & ID Number St Ann's Healthcare Center # 0023390 Report Period Beginning: 01-01-08 Ending: 12-31-08

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	\$ 137,340	\$ 14,669	\$ 14,669	\$	8	\$ 80,927	71
72	Current Year Purchases	7,018	658	658		8	658	72
73	Fully Depreciated Assets	25,437				8	24,437	73
74								74
75	TOTALS	\$ 169,795	\$ 15,327	\$ 15,327	\$		\$ 106,022	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	2007 Dodge Caravan	2007	\$ 18,605	\$ 3,778	\$ 3,778	\$	5	\$ 4,124	76
77		2008 Dodge Caravan	2008	16,970	1,131	1,131		5	1,131	77
78										78
79										79
80	TOTALS			\$ 35,575	\$ 4,909	\$ 4,909	\$		\$ 5,255	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)	\$ 1,992,440	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 65,667	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 65,667	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,485,692	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

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

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

**XII. RENTAL COSTS**

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

1. Name of Party Holding Lease: \_\_\_\_\_

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	<b>TOTAL</b>				\$ _____			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.	_____ /2009	\$ _____
13.	_____ /2010	\$ _____
14.	_____ /2011	\$ _____

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

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

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

Facility Name & ID Number St Ann's Healthcare Center # 0023390 Report Period Beginning: 01-01-08 Ending: 12-31-08

**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>
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**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)	
<b>TOTAL TRAINED</b>	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the 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		3		4		5		6		7		8		
			Staff		Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)						
			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 prescripts														9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs														10
11	Academic Education		hrs														11
12	Other (specify):																12
13	Other (specify):																13
14	TOTAL			\$				\$		\$			\$				14

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

Facility Name & ID Number St Ann's Healthcare Center# 0023390Report Period Beginning: 01-01-08

Ending:

12-31-08

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12-31-08

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 232,631	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	1,542,704		3
4	Supply Inventory (priced at )	31,931		4
5	Short-Term Investments	250,075		5
6	Prepaid Insurance	39,411		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 2,096,752	\$	10
	<b>B. Long-Term Assets</b>			
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	265,073		16
17	Accumulated Depreciation (book methods)	(1,485,692)		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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 486,748	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 2,583,500	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 45,736	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	11,754		29
30	Accrued Salaries Payable	56,346		30
31	Accrued Taxes Payable (excluding real estate taxes)	31,549		31
32	Accrued Real Estate Taxes(Sch.IX-B)	1,885		32
33	Accrued Interest Payable	56,336		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 203,606	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	2,560,496		39
40	Mortgage Payable	305,545		40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 2,866,041	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 3,069,647	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (486,147)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 2,583,500	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (575,027)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (575,027)	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	88,880	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)	\$ 88,880	17
<b>B. Transfers (Itemize):</b>			
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)	\$ (486,147)	24 *

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

Facility Name & ID Number St Ann's Healthcare Center# 0023390Report Period Beginning: 01-01-08Ending: 12-31-08**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

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

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

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 2,900,965	1
2	Discounts and Allowances for all Levels	(193,648)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,707,317	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	350,219	6
7	Oxygen	14	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 350,233	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	2,809	12
13	Barber and Beauty Care	6,704	13
14	Non-Patient Meals	6,327	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	56,198	17
18	Sale of Supplies to Non-Patients	19,482	18
19	Laboratory	17,164	19
20	Radiology and X-Ray	2,371	20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 111,055	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	1,811	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 1,811	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Rebates</u>	359	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 359	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 3,170,775	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	722,327	31
32	Health Care	1,367,149	32
33	General Administration	704,219	33
<b>B. Capital Expense</b>			
34	Ownership	200,838	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	22,030	35
36	Provider Participation Fee	65,332	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 3,081,895	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	88,880	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 88,880	43

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? \_\_\_\_\_ 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:

01-01-08

Ending:

12-31-08

**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	617	617	\$ 15,323	\$ 24.83	1
2	Assistant Director of Nursing	2,088	2,088	44,497	21.31	2
3	Registered Nurses	5,003	5,147	106,323	20.66	3
4	Licensed Practical Nurses	15,670	16,830	230,183	13.68	4
5	CNAs & Orderlies	48,355	51,107	471,223	9.22	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,143	2,222	25,424	11.44	9
10	Activity Assistants	2,099	2,235	17,380	7.78	10
11	Social Service Workers	2,103	2,103	25,469	12.11	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	4,204	4,324	55,599	12.86	15
16	Dishwashers	15,857	16,689	131,659	7.89	16
17	Maintenance Workers	3,477	3,597	44,934	12.49	17
18	Housekeepers	6,248	7,024	59,096	8.41	18
19	Laundry	6,141	6,677	60,751	9.10	19
20	Administrator					20
21	Assistant Administrator	1,874	2,165	52,445	24.22	21
22	Other Administrative	4,760	5,111	49,358	9.66	22
23	Office Manager					23
24	Clerical					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	<b>TOTAL (lines 1 - 33)</b>	<b>120,639</b>	<b>127,936</b>	<b>\$ 1,389,664 *</b>	<b>\$ 10.86</b>	<b>34</b>

\* 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	96	\$ 7,235	1-3	35
36	Medical Director				36
37	Medical Records Consultant	32	3,140	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		1,459	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	1,938	11-1	44
45	Social Service Consultant	48	3,314	12-1	45
46	Other(specify)				46
47					47
48					48
49	<b>TOTAL (lines 35 - 48)</b>	<b>224</b>	<b>\$ 17,086</b>		<b>49</b>

**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	<b>TOTAL (lines 50 - 52)</b>		<b>\$</b>	<b>53</b>





**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No  
If YES, give association name and amount. \_\_\_\_\_
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? \_\_\_\_\_
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 8Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 20,434 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? N  
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. \$ 65,332  
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. \$ 7,100 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 6,327
- (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? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.