		FOR BHF USE					

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2009
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2009)

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: 0023390

Facility Name: St Ann's Healthcare Center

Address: 770 State Street (Number) Chester (City) 62233 (Zip Code)

County: Randolf

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

HFS ID Number: 37-1023098001

Date of Initial License for Current Owners: 03/01/1977

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01-01-2009 to 12-31-2009 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)	
	(Title)	
Paid Preparer	(Signed)	(Date)
	(Print Name and Title)	David Reis President
	(Firm Name & Address)	WDM Computer Services Inc. 1900 Harrison St, Quincy, IL 62301
	(Telephone)	217-228-1950 Fax # 217-222-6053

In the event there are further questions about this report, please contact:
Name: Mike Greer Telephone Number: 618-826-2314
Email Address:

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

Facility Name & ID Number St Ann's Healthcare Center # 0023390 Report Period Beginning: 01-01-2009 Ending: 12-31-2009

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	32	Skilled (SNF)	32	11,680	1
2		Skilled Pediatric (SNF/PED)			2
3	87	Intermediate (ICF)	87	31,755	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	119	TOTALS	119	43,435	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	1,757		2,549	4,306	8
9	SNF/PED					9
10	ICF	7,702	10,604		18,306	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,459	10,604	2,549	22,612	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 52.06%

D. How many bed-hold days during this year were paid by the Department?
None (Do not include bed-hold days in Section B.)

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

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

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

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

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 [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 32 and days of care provided 2,549

Medicare Intermediary Wisconsin Physician Services Insurance Corporation

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

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

Tax Year: 2009 Fiscal Year: 2009

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

Facility Name & ID Number St Ann's Healthcare Center # 0023390 Report Period Beginning: 01-01-2009 Ending: 12-31-2009

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	192,558	14,184	7,408	214,150		214,150	0	214,150			1
2	Food Purchase		122,285		122,285	(6,093)	116,192	(7,389)	108,803			2
3	Housekeeping	58,969	18,945	994	78,908		78,908	0	78,908			3
4	Laundry	59,223	11,395		70,618		70,618	0	70,618			4
5	Heat and Other Utilities			102,460	102,460		102,460	0	102,460			5
6	Maintenance	44,257	15,668	55,024	114,949		114,949	0	114,949			6
7	Other (specify):* Sales Tax			37	37		37	(37)	0			7
8	TOTAL General Services	355,007	182,477	165,923	703,407	(6,093)	697,314	(7,426)	689,888			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000	0	6,000			9
10	Nursing and Medical Records	921,036	156,382	3,302	1,080,720		1,080,720	(12,749)	1,067,971			10
10a	Therapy				0		0	0	0			10a
11	Activities	42,712	7,771	2,986	53,469		53,469	0	53,469			11
12	Social Services	25,677	692	3,652	30,021		30,021	0	30,021			12
13	CNA Training				0		0	0	0			13
14	Program Transportation		5,244		5,244		5,244	0	5,244			14
15	Other (specify):* Penalty			5,000	5,000		5,000	(5,000)	0			15
16	TOTAL Health Care and Programs	989,425	170,089	20,940	1,180,454	0	1,180,454	(17,749)	1,162,705			16
	C. General Administration											
17	Administrative	52,042			52,042		52,042	0	52,042			17
18	Directors Fees				0		0	0	0			18
19	Professional Services			146,766	146,766		146,766	(120,000)	26,766			19
20	Dues, Fees, Subscriptions & Promotions			27,585	27,585		27,585	(23,641)	3,944			20
21	Clerical & General Office Expenses	45,320	23,515	17,577	86,412		86,412	0	86,412			21
22	Employee Benefits & Payroll Taxes			201,198	201,198	6,093	207,291	0	207,291			22
23	Inservice Training & Education			572	572		572	0	572			23
24	Travel and Seminar			4,746	4,746		4,746	0	4,746			24
25	Other Admin. Staff Transportation				0		0	0	0			25
26	Insurance-Prop.Liab.Malpractice			66,664	66,664		66,664	0	66,664			26
27	Other (specify):* Bad Debts			26,870	26,870		26,870	(26,870)	0			27
28	TOTAL General Administration	97,362	23,515	491,978	612,855	6,093	618,948	(170,511)	448,437			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,441,794	376,081	678,841	2,496,716	0	2,496,716	(195,686)	2,301,030			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: 01-01-2009 Ending: 12-31-2009

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			65,180	65,180		65,180	0	65,180			30
31	Amortization of Pre-Op. & Org.				0		0	0	0			31
32	Interest			117,670	117,670		117,670	(3,928)	113,742			32
33	Real Estate Taxes			34,085	34,085		34,085	0	34,085			33
34	Rent-Facility & Grounds				0		0	0	0			34
35	Rent-Equipment & Vehicles				0		0	0	0			35
36	Other (specify):* St. Rpcmt Tax			1,543	1,543		1,543	(1,543)	0			36
37	TOTAL Ownership			218,478	218,478	0	218,478	(5,471)	213,007			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			44	44		44	0	44			38
39	Ancillary Service Centers			240,369	240,369		240,369	0	240,369			39
40	Barber and Beauty Shops			5,430	5,430		5,430	0	5,430			40
41	Coffee and Gift Shops		10,522		10,522		10,522	0	10,522			41
42	Provider Participation Fee			65,153	65,153		65,153	0	65,153			42
43	Other (specify):*				0		0	0	0			43
44	TOTAL Special Cost Centers	0	10,522	310,996	321,518	0	321,518	0	321,518			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,441,794	386,603	1,208,315	3,036,712	0	3,036,712	(201,157)	2,835,555			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: 01-01-2009 Ending: 12-31-2009

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(5,533)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients	(12,749)	10		7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(3,928)	32		10
11	Discounts, Allowances, Rebates & Refunds	(1,856)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(37)	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	(995)	20		17
18	Fines and Penalties	(5,000)	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	(26,870)	27		24
25	Fund Raising, Advertising and Promotional	(22,646)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,543)	36		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)**	$ (81,157)		$ 0	30

BHF USE ONLY									
48		49		50		51		52	

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

		1 Amount	2 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)	(120,000)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (120,000)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (201,157)		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 Yes	2 No	3 Amount	4 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	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

St Ann's Healthcare Center

ID# 0023390

Report Period Beginning: 01-01-2009

Ending: 12-31-2009

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number St Ann's Healthcare Center # 0023390 Report Period Beginning: 01-01-2009 Ending: 12-31-2009

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(7,389)	0	0	0	0	0	0	0	0	0	0	(7,389)	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):*	(37)	0	0	0	0	0	0	0	0	0	0	(37)	7
8	**TOTAL General Services**	(7,426)	0	0	0	0	0	0	0	0	0	0	(7,426)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(12,749)	0	0	0	0	0	0	0	0	0	0	(12,749)	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):*	(5,000)	0	0	0	0	0	0	0	0	0	0	(5,000)	15
16	**TOTAL Health Care and Programs**	(17,749)	0	0	0	0	0	0	0	0	0	0	(17,749)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(120,000)	0	0	0	0	0	0	0	0	0	(120,000)	19
20	Fees, Subscriptions & Promotions	(23,641)	0	0	0	0	0	0	0	0	0	0	(23,641)	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):*	(26,870)	0	0	0	0	0	0	0	0	0	0	(26,870)	27
28	**TOTAL General Administration**	(50,511)	(120,000)	0	0	0	0	0	0	0	0	0	(170,511)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(75,686)	(120,000)	0	0	0	0	0	0	0	0	0	(195,686)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number St Ann's Healthcare Center # 0023390 Report Period Beginning: 01-01-2009 Ending: 12-31-2009

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

	Capital Expense D. Ownership	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)	
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	(3,928)	0	0	0	0	0	0	0	0	0	0	(3,928)	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):*	(1,543)	0	0	0	0	0	0	0	0	0	0	(1,543)	36
37	**TOTAL Ownership**	(5,471)	0	0	0	0	0	0	0	0	0	0	(5,471)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(81,157)	(120,000)	0	0	0	0	0	0	0	0	0	(201,157)	45

Facility Name & ID Number St Ann's Healthcare Center # 0023390 Report Period Beginning: 01-01-2009 Ending: 12-31-2009

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, Anns Healthcare	Chester	RDR Mgmt	Hoyleton	Mgmt
Mike Greer	25	St, Anns Healthcare	Chester	Greer Mgmt	Carlyle	Mgmt
Gail Greer	25	St, Anns Healthcare	Chester	Manor at Craig Farms	Chesrer	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 [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	Management	$ 60,000	Greer Management		$	$ (60,000)	1
2	V	19		60,000	RDR management			(60,000)	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			$ 120,000			$	$ * (120,000)	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: 01-01-2009 Ending: 12-31-2009

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	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
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	18,750	4					6
7	Mike Greer	Secretary	Clinton Manor	12.50	9,375	4					7
8	Gail Greer	Director	Clinton Manor	12.50	9,375						8
9	Blain Richard	RDR Mgmt	Clinton Manor		28,800	4					9
10	Mike Greer	Greer Mgmt	Clinton Manor		28,800	4					10
11	Blain Richard	RDR Mgmt	So ILL Comm Sup		13,835	2					11
12	Mike Greer	Greer Mgmt	So ILL Comm Sup		13,835	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: 01-01-2009 Ending: 2-31-2009

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 [X]

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

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

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

Facility Name & ID Number St Ann's Healthcare Center # 0023390 Report Period Beginning: 01-01-2009 Ending: 12-31-2009

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	First National Bank		X	Mortgage	$3,547.36	09/15/08	$ 850,000	$ 282,418	09/15/11	6.5000	$ 19,440	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Owner Loans	X		Cash Flow		04/01/09	1,944,677	1,944,677	03/31/10	3.0000	56,650	6
7	Buena Vista		X	Line of Credit	$5,153.00	11/18/08	673,815	651,343	11/18/11	6.2500	41,023	7
8	Fifth Third Bank		X	Auto Loan	$566.76	10/12/07	18,605	5,509	10/23/10	6.0000	557	8
9	TOTAL Facility Related				$9,267.12		$ 3,487,097	$ 2,883,947			$ 117,670	9
	B. Non-Facility Related*											
10	Interest Income										(3,928)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$ 0	$ 0			$ (3,928)	14
15	TOTALS (line 9+line14)						$ 3,487,097	$ 2,883,947			$ 113,742	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.)

Facility Name & ID Number St Ann's Healthcare Center # 0023390 Report Period Beginning: 01-01-2009 Ending: 12-31-2009

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and

1. Real Estate Tax accrual used on 2008 report.	$ 1,885	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.)	$ 2008 34085	2
3. Under or (over) accrual (line 2 minus line 1).	$	3
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)	$ 1,885	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.	$ 34,085	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:

2004	33,418	8
2005	31,530	9
2006	32,334	10
2007	32,546	11
2008	34,085	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2008	$	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:** 2008 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 2008 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2008.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2008 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 2009 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.

2008 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 2008 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 2008.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	18-034-011-00	Nursing Home Property	$ 33,496.90	$ 33,496.90
2.	18-037-005-00	Nursing Home Property	$ 104.90	$ 104.90
3.	18-040-003-00	Nursing Home Property	$ 236.82	$ 236.82
4.	18-037-006-00	Nursing Home Property	$ 160.38	$ 160.38
5.	18-034-009-00	Nursing Home Property	$ 86.42	$ 86.42
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 34,085.42	$ 34,085.42

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 and 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 2008 tax bills which were listed in Section A to this statement. Be sure to use the 2008 tax bill which is normally paid during 2009.

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: 01-01-2009 Ending: 12-31-2009

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? [X] (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? [X] (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 [X] 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	Facility	103,500	1977	$ 20,000	1
2					2
3	TOTALS	103,500		$ 20,000	3

Facility Name & ID Number St Ann's Healthcare Center # 0023390 Report Period Beginning: 01-01-2009 Ending: 12-31-2009

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		248,779	5
6	10		1985	1985	104,150	3,171	33	3,171		78,516	6
7	15		1897	1987	344,144	10,417	33	10,417		233,029	7
8			1991	1991	357,704	11,964	33	11,964		215,136	8
	Improvement Type**										
9	BUILDING IMP			1978	500		8			500	9
10	NEW ROOF			1983	9,450		15			9,450	10
11	BUILDING IMP			1983	4,469		15			4,469	11
12	ELECTRICAL IMP			1985	3,130		15			3,130	12
13	ROOF REPAIRS			1987	1,830		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		11,760	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		15			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		37,701	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		8,359	26
27	HANDRAILS			1995	20,700		8			20,700	27
28	BOILER			1995	21,690	1,455	15	1,455		20,598	28
29	ELECTRIAL,FIRE ALARM			1997	12,017	236	8	236		10,306	29
30	NEW ROOF			1999	30,546	1,535	20	1,535		16,281	30
31	NEW ROOF			2000	3,990	266	15	266		2,461	31
32	A/C UNIT			2000	7,265		8			7,265	32
33	FLOORING			2004	15,971	1,077	15	1,077		6,099	33
34	A/C UNIT			2004	6,378	806	8	806		4,297	34
35	SECURITY ALARM			2004	5,143	644	8	644		3,480	35
36	WASHER			2004	7,887	986	8	986		5,094	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: 01-01-2009 Ending: 12-31-2009

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Sign	2006	$ 5,593	$ 717	8	$ 717	$	$ 26,667	37
38	Water Htr	2006	6,479	823	8	823		2,983	38
39	AC/HTR unit	2006	13,021	868	8	868		2,894	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	$ 45,174		$ 45,174	$ 0	$ 1,447,090	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: 01-01-2009 Ending: 12-31-2009

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	$ 104,697	$ 12,834	$ 12,834	$ 0	8	$ 46,298	71
72	Current Year Purchases				0			72
73	Fully Depreciated Assets	45,058			0	8	45,058	73
74					0			74
75	TOTALS	$ 149,755	$ 12,834	$ 12,834	$ 0		$ 91,356	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	$ 0	5	$ 7,901	76
77		2008 Dodge Caravan	2008	16,970	3,394	3,394	0	5	4,525	77
78							0			78
79							0			79
80	TOTALS			$ 35,575	$ 7,172	$ 7,172	$ 0		$ 12,426	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)	$ 1,972,400	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 65,180	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 65,180	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 0	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,550,872	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 St Ann's Healthcare Center # 0023390 Report Period Beginning: 01-01-2009 Ending: 12-31-2009

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

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: *

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.	/2010	$
13.	/2011	$
14.	/2012	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number St Ann's Healthcare Center # 0023390 Report Period Beginning: 01-01-2009 Ending: 12-31-2009

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

[ ] YES
[X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
COMMUNITY COLLEGE [ ]
HOURS PER CNA ____

3. CLINICAL PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$ 0
2	Books and Supplies				0
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	CNA Competency Tests				0
9	TOTALS	$ 0	$ 0	$ 0	$ 0
10	SUM OF line 9, col. 1 and 2 (e)	$ 0			

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number St Ann's Healthcare Center # 0023390 Report Period Beginning: 01-01-2009 Ending: 12-31-2009

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

	Service	1 Schedule V Line & Column Reference	2 Staff Units of Service	3 Staff Cost	4 Outside Practitioner (other than consultant) Units	5 Outside Practitioner (other than consultant) Cost	6 Supplies (Actual or) Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$ 112,654	$		$ 112,654	1
2	Licensed Speech and Language Development Therapist		hrs			8,920			8,920	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			106,730			106,730	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Lab	39-3					11,100		11,100	12
13	Other (specify): IV	39-3					965		965	13
14	TOTAL			$		$ 228,304	$ 12,065		$ 240,369	14

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

Facility Name & ID Number St Ann's Healthcare Center # 0023390 Report Period Beginning: 01-01-2009 Ending: 12-31-2009

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12-31-2009 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 53,267	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,697,707		3
4	Supply Inventory (priced at)	33,861		4
5	Short-Term Investments	301,420		5
6	Prepaid Insurance	6,559		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,092,814	$ 0	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	20,000		13
14	Buildings, at Historical Cost	1,687,367		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	265,073		16
17	Accumulated Depreciation (book methods)	(1,550,872)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 421,568	$ 0	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,514,382	$ 0	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 40,446	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	5,509		29
30	Accrued Salaries Payable	56,509		30
31	Accrued Taxes Payable (excluding real estate taxes)	30,407		31
32	Accrued Real Estate Taxes(Sch.IX-B)	1,885		32
33	Accrued Interest Payable	56,650		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 191,406	$ 0	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	2,596,020		39
40	Mortgage Payable	282,418		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,878,438	$ 0	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,069,844	$ 0	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (555,462)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,514,382	$ 0	48

*(See instructions.)

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (486,147)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (486,147)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	15,290	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	(84,605)	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)**	$ (69,315)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 0	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (555,462)	24 *

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

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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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,867,168	1
2	Discounts and Allowances for all Levels	(239,366)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,627,802	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	336,672	6
7	Oxygen	2,033	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 338,705	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	2,368	12
13	Barber and Beauty Care	5,899	13
14	Non-Patient Meals	5,533	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	46,231	17
18	Sale of Supplies to Non-Patients	12,749	18
19	Laboratory	4,654	19
20	Radiology and X-Ray	1,256	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 78,690	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	3,928	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 3,928	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Rebates	1,056	28
28a	Activities	1,821	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,877	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,052,002	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	703,407	31
32	Health Care	1,180,454	32
33	General Administration	612,855	33
	B. Capital Expense		
34	Ownership	218,478	34
	C. Ancillary Expense		
35	Special Cost Centers	256,365	35
36	Provider Participation Fee	65,153	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,036,712	40
41	**Income before Income Taxes (line 30 minus line 40)****	15,290	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 15,290	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.

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,167	2,191	$ 53,281	$ 24.32	1
2	Assistant Director of Nursing	2,016	2,016	44,335	21.99	2
3	Registered Nurses	3,739	3,883	80,113	20.63	3
4	Licensed Practical Nurses	16,384	17,096	251,016	14.68	4
5	CNAs & Orderlies	51,161	53,457	492,291	9.21	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,054	2,094	24,750	11.82	9
10	Activity Assistants	2,114	2,242	17,962	8.01	10
11	Social Service Workers	2,001	2,088	25,677	12.30	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	4,220	4,508	58,595	13.00	14
15	Cook Helpers/Assistants	15,738	16,698	133,963	8.02	15
16	Dishwashers					16
17	Maintenance Workers	3,370	3,498	44,257	12.65	17
18	Housekeepers	6,419	6,691	58,969	8.81	18
19	Laundry	5,772	6,261	59,223	9.46	19
20	Administrator	2,088	2,088	52,042	24.92	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,694	4,194	45,320	10.81	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	122,937	129,005	$ 1,441,794 *	$ 11.18	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	96	$ 7,408	1-3	35
36	Medical Director		6,000	9-3	36
37	Medical Records Consultant	32	3,302	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	96	2,986	11-3	44
45	Social Service Consultant	96	3,652	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	320	$ 23,348		49

C. CONTRACT NURSES

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

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			$
Bev Froemming	Administrator		52,042
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 52,042

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
		$
Duane Morris	Lrgal	7,832
Herman Bodewes	Legal	352
WDM Computer Services	Act/Data processing	18,582
Greer Managemnet	Management	60,000
RDR Management	Management	60,000
Non Allow		(120,000)
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 26,766

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 42,613
Unemployment Compensation Insurance	21,497
FICA Taxes	106,988
Employee Health Insurance	29,321
Employee Meals	6,093
Illinois Municipal Retirement Fund (IMRF)*	
Drug Testing	779
TOTAL (agree to Schedule V, line 22, col.8)	$ 207,291

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 995
Advertising: Employee Recruitment	491
Health Care Worker Background Check	680
(Indicate # of checks performed 50)	
Patient Background Checks 45	
Dues & Subscriptions	1,244
Ill sec of state	534
Public Health	995
Advertising/promotion	22,646
2nd year license	(995)
Less: Public Relations Expense	(22,646)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 3,944

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
see attached list	4,746
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,746

**See instructions.

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

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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? **8 Yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **14,293** 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. $ **65,153**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **6,093** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **5,533**

(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?
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:

(18) Have all costs which do not relate to the provision of long term care been adjusted out 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.