FOR BHF USE

LL1

2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

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

I. IDPH License ID Number: 0041731

Facility Name: Provena St Anne Center

Address: 4405 Highcrest Road (Number) Rockford (City) 61107 (Zip Code)

County: Winnebago

Telephone Number: (815) 229-1999 **Fax #** (815) 299-1560

HFS ID Number:

Date of Initial License for Current Owners: 10/06/86

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code 501 C3			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2010 to 12/31/2010 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) Michael R. Gordon
(Title) CFO, VP of Finance

Paid Preparer
(Signed)
(Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

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

Facility Name & ID Number Provena St Anne Center # 0041731 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	120	Skilled (SNF)	120	43,800	1
2		Skilled Pediatric (SNF/PED)			2
3	59	Intermediate (ICF)	59	21,535	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	179	TOTALS	179	65,335	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	12,214	10,481	19,498	42,193	8
9	SNF/PED					9
10	ICF	6,159	5,285		11,444	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,373	15,766	19,498	53,637	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.10%

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

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [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 10/6/1986

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 10/6/1986 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 120 and days of care provided 15,973

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/10 Fiscal Year: 12/31/10

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

Facility Name & ID Number Provena St Anne Center # 0041731 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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	515,997	77,007	31,491	624,495		624,495		624,495			1
2	Food Purchase		486,958		486,958		486,958	(99,825)	387,133			2
3	Housekeeping	149,510	26,508		176,018		176,018		176,018			3
4	Laundry	9,645	11,123	147,114	167,882		167,882		167,882			4
5	Heat and Other Utilities			204,313	204,313		204,313	9,077	213,390			5
6	Maintenance	145,994	34,149	77,137	257,280		257,280	94,474	351,754			6
7	Other (specify):* Pastoral	50,352	2,912	20,263	73,527		73,527	(9,196)	64,331			7
8	TOTAL General Services	871,498	638,657	480,318	1,990,473		1,990,473	(5,470)	1,985,003			8
	B. Health Care and Programs											
9	Medical Director			21,000	21,000		21,000		21,000			9
10	Nursing and Medical Records	4,621,628	360,824	202,109	5,184,561		5,184,561		5,184,561			10
10a	Therapy			1,575,203	1,575,203		1,575,203		1,575,203			10a
11	Activities	135,531	7,100	8,339	150,970		150,970	303	151,273			11
12	Social Services	106,576		260	106,836		106,836		106,836			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	4,863,735	367,924	1,806,911	7,038,570		7,038,570	303	7,038,873			16
	C. General Administration											
17	Administrative	510,296	39,181	1,291,060	1,840,537		1,840,537	(330,814)	1,509,723			17
18	Directors Fees											18
19	Professional Services			26,116	26,116		26,116	(115,209)	(89,093)			19
20	Dues, Fees, Subscriptions & Promotions			40,944	40,944		40,944	(12,483)	28,461			20
21	Clerical & General Office Expenses			86,808	86,808		86,808	7,292	94,100			21
22	Employee Benefits & Payroll Taxes			1,572,007	1,572,007		1,572,007	380,574	1,952,581			22
23	Inservice Training & Education			1,929	1,929		1,929	561	2,490			23
24	Travel and Seminar			8,617	8,617		8,617	5,169	13,786			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			236,508	236,508		236,508	(736)	235,772			26
27	Other (specify):* Bad Debt			78,496	78,496		78,496	(78,496)				27
28	TOTAL General Administration	510,296	39,181	3,342,485	3,891,962		3,891,962	(144,142)	3,747,820			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,245,529	1,045,762	5,629,714	12,921,005		12,921,005	(149,309)	12,771,696			29

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

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

Facility Name & ID Number Provena St Anne Center #0041731 **Report Period Beginning:** 1/1/2010 **Ending:** 12/31/2010

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			409,086	409,086		409,086	134,951	544,037			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							713,629	713,629			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds							29,150	29,150			34
35	Rent-Equipment & Vehicles			20,967	20,967		20,967	3,728	24,695			35
36	Other (specify):*											36
37	**TOTAL Ownership**			430,053	430,053		430,053	881,458	1,311,511			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			1,320,604	1,320,604		1,320,604	(483,594)	837,010			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			98,271	98,271		98,271		98,271			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			1,418,875	1,418,875		1,418,875	(483,594)	935,281			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	6,245,529	1,045,762	7,478,642	14,769,933		14,769,933	248,555	15,018,488			45

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

Facility Name & ID Number Provena St Anne Center # 0041731 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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	(103,522)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	10,382	30		9
10	Interest and Other Investment Income	(9,879)	32		10
11	Discounts, Allowances, Rebates & Refunds	(483,594)	39		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(494)	21		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	(1,300)	21		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	(78,496)	27		24
25	Fund Raising, Advertising and Promotional	(17,346)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(2,454)	20		28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (686,703)		$	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)	944,454		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (9,196)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (695,899)		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

Provena St Anne Center

ID# 0041731

Report Period Beginning: 1/1/2010

Ending: 12/31/2010

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Office Supplies	$ (897)	7	1
2	Other Supplies	(347)	7	2
3	Advert/Marketing	(4,332)	7	3
4	Miscellaneous	(2,938)	7	4
5	Gifts	(682)	7	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**	(9,196)		49

STATE OF ILLINOIS **Summary A**

Facility Name & ID Number Provena St Anne Center **#** 0041731 **Report Period Beginning:** 1/1/2010 **Ending:** 12/31/2010

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	(103,522)	3,697	0	0	0	0	0	0	0	0	0	(99,825)	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	9,077	0	0	0	0	0	0	0	0	0	9,077	5
6	Maintenance	0	1,700	92,774	0	0	0	0	0	0	0	0	94,474	6
7	Other (specify):*	(9,196)	0	0	0	0	0	0	0	0	0	0	(9,196)	7
8	**TOTAL General Services**	(112,718)	14,474	92,774	0	0	0	0	0	0	0	0	(5,470)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	303	0	0	0	0	0	0	0	0	0	303	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	303	0	0	0	0	0	0	0	0	0	303	16
	C. General Administration													
17	Administrative	0	(515,963)	185,149	0	0	0	0	0	0	0	0	(330,814)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	19,409	(134,618)	0	0	0	0	0	0	0	0	(115,209)	19
20	Fees, Subscriptions & Promotions	(19,800)	7,317	0	0	0	0	0	0	0	0	0	(12,483)	20
21	Clerical & General Office Expenses	(1,794)	9,086	0	0	0	0	0	0	0	0	0	7,292	21
22	Employee Benefits & Payroll Taxes	0	85,687	294,887	0	0	0	0	0	0	0	0	380,574	22
23	Inservice Training & Education	0	561	0	0	0	0	0	0	0	0	0	561	23
24	Travel and Seminar	0	5,169	0	0	0	0	0	0	0	0	0	5,169	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	(736)	0	0	0	0	0	0	0	0	0	(736)	26
27	Other (specify):*	(78,496)	0	0	0	0	0	0	0	0	0	0	(78,496)	27
28	**TOTAL General Administration**	(100,090)	(389,470)	345,418	0	0	0	0	0	0	0	0	(144,142)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(212,808)	(374,693)	438,192	0	0	0	0	0	0	0	0	(149,309)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Provena St Anne Center # 0041731 **Report Period Beginning:** 1/1/2010 **Ending:** 12/31/2010

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	10,382	0	124,569	0	0	0	0	0	0	0	0	134,951	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(9,879)	0	723,508	0	0	0	0	0	0	0	0	713,629	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	29,150	0	0	0	0	0	0	0	0	29,150	34
35	Rent-Equipment & Vehicles	0	0	3,728	0	0	0	0	0	0	0	0	3,728	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	503	0	880,955	0	0	0	0	0	0	0	0	881,458	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	(483,594)	0	0	0	0	0	0	0	0	0	0	(483,594)	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**	(483,594)	0	0	0	0	0	0	0	0	0	0	(483,594)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(695,899)	(374,693)	1,319,147	0	0	0	0	0	0	0	0	248,555	45

Facility Name & ID Number Provena St Anne Center # 0041731 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		See Attached		See Attached		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] 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 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	2	Food	$	Provena Senior Services	100.00%	$ 3,697	$ 3,697	1
2	V	5	Utilities		Provena Senior Services	100.00%	9,077	9,077	2
3	V	6	Maintenance - Other		Provena Senior Services	100.00%	1,700	1,700	3
4	V	11	Activities-Special Events		Provena Senior Services	100.00%	303	303	4
5	V	17	Admin - Misc. Other		Provena Senior Services	100.00%	6,631	6,631	5
6	V	17	Administrative Salaries	868,608	Provena Senior Services	100.00%	346,014	(522,594)	6
7	V	19	Professional Services		Provena Senior Services	100.00%	19,409	19,409	7
8	V	20	Dues,Subscriptions		Provena Senior Services	100.00%	7,317	7,317	8
9	V	21	Clerical Supplies		Provena Senior Services	100.00%	9,086	9,086	9
10	V	22	Employee Benefits		Provena Senior Services	100.00%	85,687	85,687	10
11	V	23	Education/Conference		Provena Senior Services	100.00%	561	561	11
12	V	24	Travel		Provena Senior Services	100.00%	5,169	5,169	12
13	V	26	Insurance		Provena Senior Services	100.00%	(736)	(736)	13
14	Total			$ 868,608			$ 493,915	$ * (374,693)	14

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

Facility Name & ID Number Provena St Anne Center # 0041731 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] 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 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)	
15	V	30	Depreciation	$	Provena Senior Services	100.00%	$ 4,595	$ 4,595	15
16	V	32	Interest		Provena Senior Services	100.00%	380,781	380,781	16
17	V	34	Rent - Facility		Provena Senior Services	100.00%	29,150	29,150	17
18	V	35	Rent - Equipment		Provena Senior Services	100.00%	3,728	3,728	18
19	V	17	Admin Salaries		Provena Health Services	100.00%	147,123	147,123	19
20	V	22	Employee Benefits		Provena Health Services	100.00%	100,896	100,896	20
21	V	30	Depreciation		Provena Health Services	100.00%	119,974	119,974	21
22	V	19	Admin Consulting,Other	172,806	Provena Health Services	100.00%	38,188	(134,618)	22
23	V	17	Information Systems Salaries		Provena Health Services	100.00%	153,074	153,074	23
24	V	22	Information Systems Benefits		Provena Health Services	100.00%	52,981	52,981	24
25	V	17	Information Systems - Other	249,646	Provena Health Services	100.00%	49,335	(200,311)	25
26	V	17	Admin Salaries		Provena Health Services	100.00%	22,924	22,924	26
27	V	22	Employee Benefits		Provena Health Services	100.00%	88,721	88,721	27
28	V	17	Information Systems Salaries		Provena Health Services	100.00%	62,339	62,339	28
29	V	22	Information Systems Benefits		Provena Health Services	100.00%	52,289	52,289	29
30	V	6	Information Systems - Equip Maint		Provena Health Services	100.00%	92,774	92,774	30
31	V	32	Admin - Interest Expense		Provena Health Services	100.00%	342,727	342,727	31
32	V	39	Ancillary Services - Other	1,320,604	Provena Senior Services Pharmacy	100.00%	1,320,604		32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 1,743,056			$ 3,062,203	$ * 1,319,147	39

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

Facility Name & ID Number Provena St Anne Center # 0041731 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Provena St Anne Center # 0041731 Report Period Beginning: 1/1/2010 Ending: 2/31/2010

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 [X] NO [ ]

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

Name of Related Organization: Provena Senior Services
Street Address: 19065 Hickory Creek Drive, Ste 310
City / State / Zip Code: Mokena, IL 60448
Phone Number: (708-478-7900
Fax Number: (708-478-5387

	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	2	Food	Management Fee Income	6,595,714	19	$ 28,071	$	868,608	$ 3,697	1
2	5	Utilities	Management Fee Income	6,595,714	19	68,922		868,608	9,077	2
3	6	Maintenance - Other	Management Fee Income	6,595,714	19	12,909		868,608	1,700	3
4	11	Activities-Special Events	Management Fee Income	6,595,714	19	2,299		868,608	303	4
5	17	Admin - Misc. Other	Management Fee Income	6,595,714	19	50,355		868,608	6,631	5
6	17	Administrative Salaries	Management Fee Income	6,595,714	19	2,627,432	2,627,432	868,608	346,014	6
7	19	Professional Services	Management Fee Income	6,595,714	19	147,379		868,608	19,409	7
8	20	Dues,Subscriptions	Management Fee Income	6,595,714	19	55,559		868,608	7,317	8
9	21	Clerical Supplies	Management Fee Income	6,595,714	19	68,996		868,608	9,086	9
10	22	Employee Benefits	Management Fee Income	6,595,714	19	650,662		868,608	85,687	10
11	23	Education/Conference	Management Fee Income	6,595,714	19	4,261		868,608	561	11
12	24	Travel	Management Fee Income	6,595,714	19	39,252		868,608	5,169	12
13	26	Insurance	Management Fee Income	6,595,714	19	(5,591)		868,608	(736)	13
14	30	Depreciation	Management Fee Income	6,595,714	19	34,889		868,608	4,595	14
15	32	Interest	Management Fee Income	6,595,714	19	2,891,431		868,608	380,781	15
16	34	Rent - Facility	Management Fee Income	6,595,714	19	221,352		868,608	29,150	16
17	35	Rent - Equipment	Management Fee Income	6,595,714	19	28,311		868,608	3,728	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 6,926,489	$ 2,627,432		$ 912,169	25

Facility Name & ID Number Provena St Anne Center # 0041731 Report Period Beginning: 1/1/2010 Ending: 2/31/2010

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 [X] NO [ ]

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

Name of Related Organization: Provena Health Services
Street Address: 9223 West St. Francis Road
City / State / Zip Code: Frankfort, IL 60423
Phone Number: (815-469-4888
Fax Number: (815-469-4864

	1 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	17	Admin Salaries	Operating Expense	1,061,750	10	$ 903,952	$ 903,952	172,806	$ 147,123	1
2	22	Employee Benefits	Operating Expense	1,061,750	10	619,921		172,806	100,896	2
3	30	Depreciation	Operating Expense	1,061,750	10	737,143		172,806	119,974	3
4	34	Rent Facility	Operating Expense	1,061,750	10	234,632		172,806	38,188	4
5	19	Admin Consulting,Other	Operating Expense	1,061,750	10	940,516		172,806	153,074	5
6	17	Information Systems Salaries	Operating Expense	1,712,144	10	363,360	363,360	249,646	52,981	6
7	22	Information Systems Benefits	Operating Expense	1,712,144	10	338,352		249,646	49,335	7
8	17	Information Systems - Other	Operating Expense	1,712,144	10	157,216		249,646	22,924	8
9	17	Admin Salaries	Direct Cost	1,061,750	10	545,118	545,118	172,806	88,721	9
10	17	Information Systems Salaries	Direct Cost	1,712,144	10	427,541	427,541	249,646	62,339	10
11	6	Information Systems - Equip Mair	Direct Cost	1,712,144	10	358,615		249,646	52,289	11
12	19	Admin Consulting,Other	Direct Cost	1,061,750	10	570,021		172,806	92,774	12
13	32	Admin - Interest Expense	Direct Cost	1,061,750	10	2,105,774		172,806	342,727	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					$ 8,302,161	$ 2,239,971		$ 1,323,345	25

Facility Name & ID Number Provena St Anne Center # 0041731 Report Period Beginning: 1/1/2010 Ending: 2/31/2010

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 [X] NO [ ]

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

Name of Related Organization: Provena Senior Services Pharmacy
Street Address: 1475 Harvard Drive
City / State / Zip Code: Kankakee, IL 60901
Phone Number: (815-928-6141
Fax Number: (815-946-3238

	1 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	39	Ancillary Services - Other	Direct Allocation			$	$		$ 1,320,604	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 1,320,604	25

Facility Name & ID Number Provena St Anne Center # 0041731 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Home Office Allocation						$	$			$ 723,508	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 723,508	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$ 723,508	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 Provena St Anne Center **#** 0041731 **Report Period Beginning:** 1/1/2010 **Ending:** 12/31/2010

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	2
3. Under or (over) accrual (line 2 minus line 1).	$	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)	$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.**	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	2005	8
	2006	9
	2007	10
	2008	11
	2009	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2009	$	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.

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Provena St Anne Center COUNTY Winnebago

FACILITY IDPH LICENSE NUMBER 0041731

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2009 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 2009.

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

B. **Real Estate Tax Cost Allocations**

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

If YES, attach an explanation 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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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

Facility Name & ID Number Provena St Anne Center # 0041731 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 70,000 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

C. Does the Operating Entity? [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. [X] (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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Home		1985	$ 639,976	1
2					2
3	TOTALS			$ 639,976	3

Facility Name & ID Number Provena St Anne Center # 0041731 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	120		1986	1986	$ 3,516,907	$ 100,483	35	$ 100,483	$	$ 2,540,214	4
5	59		1993	1993	2,722,251	90,742	30	90,742		1,579,672	5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1986							9
10	Various			1990	34,784	1,122	31	1,122		23,002	10
11	Various			1992	471		10			471	11
12	Various			1993	1,623		30			1,623	12
13	Various			1994	5,000		10			5,000	13
14	Various			1995	40,225	1,271	24	1,271		27,091	14
15	Various			1996	11,192	535	12	535		10,925	15
16	Various			1997	40,121	892	9	892		40,208	16
17	Various			1998	24,514		5			25,080	17
18	Various			1999	6,269		5			6,269	18
19	Various			2000	27,043	286	6	286		27,288	19
20	Various			2001	283,276	18,849	14	18,849		209,665	20
21	Various			2002	11,068	586	12	586		8,023	21
22	Various			2003	30,574	2,786	9	2,786		28,222	22
23	Various			2004	46,460	3,587	9	3,587		34,432	23
24	Various			2005	34,969	2,887	13	2,887		15,543	24
25	Various			2006	87,852	9,418	11	9,418		41,389	25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Provena St Anne Center # 0041731 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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	MAIN NURSES STATION	2007	$ 12,500	$ 833	15	$ 833	$	$ 2,917	37
38	INSTALL ACOUSTICALCEILINF& TILE FO	2007	36,500	3,650	10	3,650		12,775	38
39	ELECTRICAL WORK	2007	9,609	961	10	961		3,363	39
40	(19) SUPPLY/RETURNGRILLESINTO NEW	2007	3,280	469	7	469		1,640	40
41	10 TON ROOFTOP UNITWITH GAS HEAT,EC	2007	11,889	793	15	793		2,774	41
42	SPRINKLERSYSTEM /CONCRETE	2007	750	30	25	30		105	42
43	CABINETSAND COUNTERTOPS	2007	12,516	834	15	834		2,920	43
44	REPLACE FIRE SPRINKLER MAINS	2007	66,669	6,667	10	6,667		23,200	44
45	VINYL FLOORING & CARPET FORLOBBY	2007	7,886	789	10	789		2,784	45
46	BUILD 25UNITS (ROOM DIVIDERS)	2007	19,250	1,925	10	1,925		5,775	46
47	VOICE ANNOUNCEMENTUNIT	2007	4,530	453	10	453		1,359	47
48	ELECTRICAL FOR KITCHEN EQUIP IN NEW	2007	6,376	425	15	425		1,275	48
49									49
50									50
51	ECO FRIENDLY GREENHOUSE	2008	475	19	25	19		48	51
52	ROOF REPAIRS	2008	29,859	2,986	10	2,986		7,465	52
53	CAFE REMODEL	2008	765	77	10	77		191	53
54	MCQUAY PTAC UNITS	2008	10,900	727	15	727		1,817	54
55	STAIN EXTERIOR BOARD AND TRIM	2008	3,650	521	7	521		1,304	55
56	(11) THERMO WINDOWS	2008	7,700	385	20	385		963	56
57	NURSE CALL SYSTEM	2008	61,170	6,117	10	6,117		15,293	57
58	FIRE DAMPERS	2008	4,101	410	10	410		1,025	58
59	CARESENSECHAIR MONITORINGSYSTEM/BE	2008	9,706	971	10	971		2,427	59
60	SEALCOATING OF PARKING LOT	2008	2,781	348	8	348		869	60
61	INSTALLATION OF 10AND SERVICE TO EX	2008	6,920	692	10	692		1,730	61
62									62
63	REPLACE CONTROL VALVES REPIPE DRAIN	2009	2,980	199	15	199		298	63
64	PARKING LOT REPAIRS/SEALCOATING	2009	14,252	2,036	7	2,036		3,054	64
65	DOOR CLOSURE & SMOKE DETECTORS	2009	19,361	1,936	10	1,936		2,904	65
66	ANSUL SYSTEM IN DIETARY	2009	3,334	333	10	333		500	66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 7,294,309	$ 269,029		$ 269,029	$	$ 4,724,891	70

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

Facility Name & ID Number Provena St Anne Center # 0041731 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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	
1	Totals from Page 12A, Carried Forward		$ 7,294,309	$ 269,029		$ 269,029	$	$ 4,724,891	1
2	REPLACEMENT OF EXISTING LINES IN CAF	2010	6,420	321	10	642	321	321	2
3	GENERATORREPAIRS	2010	10,824	1,082	5	2,165	1,082	1,082	3
4	WALL, TILE, AND SINKS	2010	10,686	534	10	1,069	534	534	4
5	SPA UNITS	2010	55,425	1,848	15	3,695	1,848	1,848	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	TOTAL (lines 1 thru 33)		$ 7,377,664	$ 272,814		$ 276,599	$ 3,785	$ 4,728,676	34

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

Facility Name & ID Number Provena St Anne Center # 0041731 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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	$ 1,286,701	$ 129,675	$ 129,675	$	11	$ 582,664	71
72	Current Year Purchases	133,404	6,597	13,194	6,597	11	6,597	72
73	Fully Depreciated Assets	308,892				6	308,892	73
74	Home Office Allocation		124,569	124,569				74
75	TOTALS	$ 1,728,997	$ 260,841	$ 267,438	$ 6,597		$ 898,153	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Plant Engineering	1998 MINI-VAN(LOU BACHRO	1998	$ 43,500	$	$	$	5	$ 43,500	76
77	Plant Engineering	F150 FORDWITH SNOWPLOW	1999	23,172				3	23,172	77
78										78
79										79
80	TOTALS			$ 66,672	$	$	$		$ 66,672	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 9,813,309	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 533,655	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 544,037	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 10,382	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 5,693,501	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Provena St Anne Center # 0041731 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Home Office Allocation				29,150			5
6								6
7	TOTAL				$ 29,150 **			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 [X] 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.	/2011	$
13.	/2012	$
14.	/2013	$

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

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 224,110 Description: Nursing $185,948; Activities $43; Plant $13,424; Admin $20,967; Home Office $3728
(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 Provena St Anne Center # 0041731 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

STATE OF ILLINOIS

Facility Name & ID Number Provena St Anne Center # 0041731 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a,3	hrs	$	9,794	$ 700,353	$	9,794	$ 700,353	1
2	Licensed Speech and Language Development Therapist	10a,3	hrs		1,138	88,216		1,138	88,216	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a,3	hrs		10,656	786,634		10,656	786,634	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39,3	# of prescrpts				1,320,604		1,320,604	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			$	21,588	$ 1,575,203	$ 1,320,604	21,588	$ 2,895,807	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.

STATE OF ILLINOIS

Facility Name & ID Number Provena St Anne Center # 0041731 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2010 (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	$ 12,905,317	$	1
2	Cash-Patient Deposits	106,041		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	11,828,283		3
4	Supply Inventory (priced at)	704,078		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	214,949		7
8	Accounts Receivable (owners or related parties)	49,434		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 25,808,102	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	8,146,223		12
13	Land	6,880,789		13
14	Buildings, at Historical Cost	88,483,063		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	20,359,968		16
17	Accumulated Depreciation (book methods)	(60,063,987)		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)**	$ 63,806,056	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 89,614,158	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 5,914,297	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,171,680		28
29	Short-Term Notes Payable	56,068		29
30	Accrued Salaries Payable	3,651,233		30
31	Accrued Taxes Payable (excluding real estate taxes)	120,716		31
32	Accrued Real Estate Taxes(Sch.IX-B)	1,242,086		32
33	Accrued Interest Payable	12,331		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to Related Party	1,099,900		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 13,268,311	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,108,871		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	442,616		42
	Other Long-Term Liabilities(specify):			
43	Conditional Asset Retirement	438,744		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,990,231	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 15,258,542	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 74,355,616	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 89,614,158	$	48

*(See instructions.)

Facility Name & ID Number Provena St Anne Center **#** 0041731 **Report Period Beginning:** 1/1/2010 **Ending:** 12/31/2010

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 73,769,457	1
2	Restatements (describe):		2
3	**Transfer to Affiliates**	(2,072,160)	3
4	**Adj. To reconcile consolidated equity & consolidated income**	1,861,400	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 73,558,697	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	685,227	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	232,870	11
12	Expenditures for Specific Purposes	(121,178)	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)**	$ 796,919	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 74,355,616	24 *

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

Facility Name & ID Number Provena St Anne Center # 0041731 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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	$ 10,768,016	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 10,768,016	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,743,128	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,743,128	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	100,911	12
13	Barber and Beauty Care	4,550	13
14	Non-Patient Meals	2,611	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,257,949	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	14,361	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,380,382	23
	D. Non-Operating Revenue		
24	Contributions	43,065	24
25	Interest and Other Investment Income***	9,879	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 52,944	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Purchase Rebates	473,715	28
28a	Misc Income & Gain/Loss SOFA	36,975	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 510,690	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 15,455,160	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,990,473	31
32	Health Care	7,038,570	32
33	General Administration	3,891,962	33
	B. Capital Expense		
34	Ownership	430,053	34
	C. Ancillary Expense		
35	Special Cost Centers	1,320,604	35
36	Provider Participation Fee	98,271	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 14,769,933	40
41	**Income before Income Taxes (line 30 minus line 40)****	685,227	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 685,227	43

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.**

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

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

Facility Name & ID Number Provena St Anne Center # 0041731 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,944	2,080	$ 97,868	$ 47.05	1
2	Assistant Director of Nursing	1,856	2,080	74,352	35.75	2
3	Registered Nurses	40,310	43,458	1,361,981	31.34	3
4	Licensed Practical Nurses	49,647	53,757	1,278,846	23.79	4
5	CNAs & Orderlies	132,481	143,038	1,700,239	11.89	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,900	8,500	108,342	12.75	8
9	Activity Director	1,872	2,080	40,580	19.51	9
10	Activity Assistants	7,718	8,516	94,951	11.15	10
11	Social Service Workers	5,527	6,086	106,576	17.51	11
12	Dietician	2,868	3,231	51,651	15.99	12
13	Food Service Supervisor	2,823	3,087	48,634	15.75	13
14	Head Cook	7,763	8,167	90,815	11.12	14
15	Cook Helpers/Assistants	30,030	31,617	324,897	10.28	15
16	Dishwashers					16
17	Maintenance Workers	7,589	8,216	145,994	17.77	17
18	Housekeepers	14,614	15,895	149,510	9.41	18
19	Laundry	1,125	1,154	9,645	8.36	19
20	Administrator	1,832	2,080	116,914	56.21	20
21	Assistant Administrator	1,744	1,912	67,456	35.28	21
22	Other Administrative	1,848	2,080	45,108	21.69	22
23	Office Manager	1,896	2,080	44,529	21.41	23
24	Clerical	6,362	6,991	73,346	10.49	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 C: Admissions	5,680	6,104	162,943	26.69	32
33	Other(specify) Pastoral	2,268	2,468	50,352	20.40	33
34	TOTAL (lines 1 - 33)	337,697	364,677	$ 6,245,529 *	$ 17.13	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	404	$ 27,489	1,3	35
36	Medical Director	140	21,000	9,3	36
37	Medical Records Consultant	35	2,377	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	48	2,592	11,3	44
45	Social Service Consultant	3	186	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	630	$ 53,644		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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

Facility Name & ID Number Provena St Anne Center # 0041731 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Janelle Chadwick	Admnistrator	0	$ 116,914
Administrative Staff	Asst Administrator	0	67,456
Administrative Staff	Office Manager	0	44,529
Administrative Staff	Human Resources	0	45,108
Administrative Staff	Receptionist	0	33,088
Administrative Staff	Admin Asst	0	40,258
Administrative Staff	Admissions	0	162,943
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 510,296

B. Administrative - Other

Description	Amount
Corp Service Fee	$ 172,806
Corp Service IS Fee	249,646
Mgmt Fee	573,804
Mgmt Fee Interest	294,804
TOTAL (agree to Schedule V, line 17, col. 3)	$ 1,291,060
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Legal Expense	Various	$ 6,894
Survey & Analytical Tools	Various	6,806
Transporation Service	Various	4,588
Collection Fees	Various	1,147
Shredding/Storage	Various	1,207
Living Design	Various	222
Outsourced Services	Various	1,252
Audit Expense	Various	4,000
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 26,116

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 176,400
Unemployment Compensation Insurance	58,794
FICA Taxes	445,465
Employee Health Insurance	644,531
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Life Insurance	25,263
Pension	186,170
Employee Recognition	320
Executive Benefits	8,232
Employee Screening	26,832
Home Office Allocation	380,574
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,952,581

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

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 81)	
Patient Background Checks 552	
Employee Recruitment	6,842
Dues & Subscription	11,685
Advertising & Public Relations	22,417
Home Office Allocation	7,317
Less: Public Relations Expense	( )
Non-allowable advertising	(17,346)
Yellow page advertising	(2,454)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 28,461

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 1,462
In-State Travel	7,155
Seminar Expense	
Home Office Allocation	5,169
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 13,786

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Provena St Anne Center # 0041731 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Provena St Anne Center # 0041731 **Report Period Beginning:** 1/1/2010 **Ending:** 12/31/2010

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Life Service Network $9206**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **54,694** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **98,271**
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. $ **N/A** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **103,522**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **KPMG**

(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.