FOR BHF USE

LL1

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.

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

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:

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		

In the event there are further questions about this report, please contact:
Name: Mike Greer **Telephone Number:** 618-826-2314
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 01/01/2010 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)
(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

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: 01/01/2010 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	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 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	2,407		2,092	4,499	8
9	SNF/PED					9
10	ICF	9,093	8,008		17,101	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,500	8,008	2,092	21,600	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 49.73%

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 2,092

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 2010 Fiscal Year: _____

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

Facility Name & ID Number St Ann's Healthcare Center # 0023390 Report Period Beginning: 01/01/2010 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	186,222	12,877	8,262	207,361		207,361		207,361			1
2	Food Purchase		119,934		119,934	(7,554)	112,380	(6,761)	105,619			2
3	Housekeeping	59,743	18,682	1,151	79,576		79,576		79,576			3
4	Laundry	58,861	8,465		67,326		67,326		67,326			4
5	Heat and Other Utilities			110,100	110,100		110,100		110,100			5
6	Maintenance	43,105	35,292	43,605	122,002		122,002	(118)	121,884			6
7	Other (specify):* Sales Tax			1,269	1,269		1,269	(1,269)				7
8	TOTAL General Services	347,931	195,250	164,387	707,568	(7,554)	700,014	(8,148)	691,866			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	917,028	104,590	218,667	1,240,285		1,240,285	(11,871)	1,228,414			10
10a	Therapy											10a
11	Activities	37,170	6,971	2,250	46,391		46,391		46,391			11
12	Social Services	25,937	567	3,605	30,109		30,109		30,109			12
13	CNA Training											13
14	Program Transportation		6,567		6,567		6,567		6,567			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	980,135	118,695	230,522	1,329,352		1,329,352	(11,871)	1,317,481			16
	C. General Administration											
17	Administrative	52,616			52,616		52,616		52,616			17
18	Directors Fees											18
19	Professional Services			110,798	110,798		110,798	(80,000)	30,798			19
20	Dues, Fees, Subscriptions & Promotions			23,890	23,890		23,890	(19,421)	4,469			20
21	Clerical & General Office Expenses	47,416	24,500	19,044	90,960		90,960		90,960			21
22	Employee Benefits & Payroll Taxes			198,535	198,535	7,554	206,089		206,089			22
23	Inservice Training & Education			874	874		874		874			23
24	Travel and Seminar			3,474	3,474		3,474		3,474			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			42,686	42,686		42,686		42,686			26
27	Other (specify):* Bad Debts			40,700	40,700		40,700	(40,700)				27
28	TOTAL General Administration	100,032	24,500	440,001	564,533	7,554	572,087	(140,121)	431,966			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,428,098	338,445	834,910	2,601,453		2,601,453	(160,140)	2,441,313			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: 01/01/2010 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			55,357	55,357		55,357		55,357			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			115,696	115,696		115,696	(5,992)	109,704			32
33	Real Estate Taxes			34,920	34,920		34,920		34,920			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* **Replmt Tax**			555	555		555	(555)				36
37	**TOTAL Ownership**			206,528	206,528		206,528	(6,547)	199,981			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			1,221	1,221		1,221		1,221			38
39	Ancillary Service Centers		39,510		39,510		39,510		39,510			39
40	Barber and Beauty Shops			3,727	3,727		3,727		3,727			40
41	Coffee and Gift Shops		8,495		8,495		8,495		8,495			41
42	Provider Participation Fee			65,153	65,153		65,153		65,153			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		48,005	70,101	118,106		118,106		118,106			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,428,098	386,450	1,111,539	2,926,087		2,926,087	(166,687)	2,759,400			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: 01/01/2010 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 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(5,562)	2		4
5	Telephone, TV & Radio in Resident Rooms	(118)	6		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients	(5,684)	10		7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(5,992)	32		10
11	Discounts, Allowances, Rebates & Refunds	(1,199)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,269)	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				18
19	Entertainment				19
20	Contributions	(6,187)	10		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(40,700)	27		24
25	Fund Raising, Advertising and Promotional	(20,416)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(555)	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)**	$ (86,687)		$	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)	(80,000)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (80,000)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (166,687)		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

St Ann's Healthcare Center

ID# 0023390

Report Period Beginning: 01/01/2010

Ending: 12/31/2010

	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:** 01/01/2010 **Ending:** 12/31/2010

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(6,761)	0	0	0	0	0	0	0	0	0	0	(6,761)	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	(118)	0	0	0	0	0	0	0	0	0	0	(118)	6
7	Other (specify):*	(1,269)	0	0	0	0	0	0	0	0	0	0	(1,269)	7
8	**TOTAL General Services**	(8,148)	0	0	0	0	0	0	0	0	0	0	(8,148)	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	(11,871)	0	0	0	0	0	0	0	0	0	0	(11,871)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(11,871)	0	0	0	0	0	0	0	0	0	0	(11,871)	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	(80,000)	0	0	0	0	0	0	0	0	0	(80,000)	19
20	Fees, Subscriptions & Promotions	(19,421)	0	0	0	0	0	0	0	0	0	0	(19,421)	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):*	(40,700)	0	0	0	0	0	0	0	0	0	0	(40,700)	27
28	**TOTAL General Administration**	(60,121)	(80,000)	0	0	0	0	0	0	0	0	0	(140,121)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(80,140)	(80,000)	0	0	0	0	0	0	0	0	0	(160,140)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number St Ann's Healthcare Center # 0023390 **Report Period Beginning:** 01/01/2010 **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	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	(5,992)	0	0	0	0	0	0	0	0	0	0	(5,992)	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):*	(555)	0	0	0	0	0	0	0	0	0	0	(555)	36
37	**TOTAL Ownership**	(6,547)	0	0	0	0	0	0	0	0	0	0	(6,547)	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)**	(86,687)	(80,000)	0	0	0	0	0	0	0	0	0	(166,687)	45

Facility Name & ID Number St Ann's Healthcare Center # 0023390 Report Period Beginning: 01/01/2010 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
Blain Richard	50	St. Ann's Healthcare	Chester	RDR MGMT	Hoyleton	Mgmt
Mike Greer	25	St. Ann's Healthcare	Chester	Greer Mgmt	Carlyle	Mgmt
Gail Greer	25	St. Ann's Healthcare	Chester	Manor at Craig Farms	Chester	Supportive Lvg
Blain Richard	25	Clinton Manor	New Baden			
Mike Greer	12.5	Clinton Manor	New Baden			
Gail Greer	12.5	Clinton Manor	New Baden			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [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 Fees	$ 40,000	Greer Mgmt		$	$ (40,000)	1
2	V	19	Management Fees	40,000	RDR Mgmt			(40,000)	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			$ 80,000			$	$ * (80,000)	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: 01/01/2010 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	Blain Richard	Secretary	Officer	50.00	St. Ann's	20	50.00		$		1
2	Mike Greer	President	Officer	25.00	St. Ann's	20	50.00				2
3	Gail Greer		Director	25.00	St. Ann's						3
4	Blain Richard	President	RDR Mgmt	100.00		10	25.00	Mgmt Fees	40,000	19-3	4
5	Mike Greer	President	Greer Mgmt	100.00		10	25.00	Mgmt Fees	40,000	19-3	5
6	Blain Richard	President	Clinton Manor	25.00	19,500	4	10.00	Wages			6
7	Mike Greer	Secretary	Clinton Manor	12.50	9,750	4	10.00	Wages			7
8	Gail Greer	Director	Clinton Manor	12.50	9,750			Wages			8
9	Blain Richard	RDR Mgmt	Clinton Manor		30,000	4	10.00	Mgmt Fees			9
10	Mike Greer	Greer Mgmt	Clinton Manor		30,000	4	10.00	Mgmt Fees			10
11	Blain Richard	RDR Mgmt	So Ill Comm Supp		15,863	2	5.00	Mgmt Fees			11
12	Mike Greer	Greer Mgmt	So Ill Comm Supp		15,863	2	5.00	Mgmt Fees			12
13								TOTAL	$ 80,000		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: 01/01/2010 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 [ ] 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: 01/01/2010 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	First National Bank		X	Mortgage	$3,547.46	09/15/08	$ 850,000	$ 257,713	09/15/11	6.5000	$ 17,716	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Owner Loans	X		Cash Flow		04/01/10	1,888,520	1,888,520	03/31/11	3.0000	56,656	6
7	Buena Vista		X	Line of Credit	$5,153.00	11/18/08	673,815	629,930	11/18/11	6.0000	40,730	7
8	First Third Bank		X	Auto Loan	$566.76	10/12/07	18,605		10/23/10	6.0000	594	8
9	TOTAL Facility Related				$9,267.22		$ 3,430,940	$ 2,776,163			$ 115,696	9
	B. Non-Facility Related*											
10	Investment income										(5,992)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (5,992)	14
15	TOTALS (line 9+line14)						$ 3,430,940	$ 2,776,163			$ 109,704	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:** 01/01/2010 **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.**	$ 1,885	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.)		$ 2009 34920	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.)		$ 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.		$ 34,920	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2005	31,530	8
2006	32,334	9
2007	32,546	10
2008	34,085	11
2009	34,920	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 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 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.	18-034-011-00	Nursing Home	$ 34,317.26	$ 34,317.26
2.	18-037-005-00	Nursing Home	$ 107.58	$ 107.58
3.	18-040-003-00	Nursing Home	$ 242.50	$ 242.50
4.	18-037-006-00	Nursing Home	$ 164.38	$ 164.38
5.	18-034-009-00	Nursing Home	$ 88.40	$ 88.40
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 34,920.12	$ 34,920.12

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 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 St Ann's Healthcare Center # 0023390 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

X. BUILDING AND GENERAL INFORMATION:

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

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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Home	105,500	1977	$ 20,000	1
2					2
3	TOTALS	105,500		$ 20,000	3

Facility Name & ID Number St Ann's Healthcare Center # 0023390 Report Period Beginning: 01/01/2010 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	48		1977	1937	$ 404,102	$	20	$	$	$ 404,102	4
5	46		1977	1976	250,000	1,221	33	1,221		250,000	5
6	10		1985	1985	104,150	3,171	33	3,171		81,687	6
7	15		1897	1987	344,144	10,417	33	10,417		243,446	7
8			1991	1991	357,704	11,964	33	11,964		227,100	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		12,263	18
19	TELEPHONE SYSTEM			1992	10,071		10			10,071	19
20	CUBICLE TRACK			1992	6,531		8			6,532	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		39,500	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		8,921	26
27	HANDRAILS			1995	20,700		8			20,700	27
28	BOILER			1995	21,690	1,091	15	1,091		21,690	28
29	ELECTRIAL,FIRE ALARM			1997	12,017	236	8	236		10,543	29
30	NEW ROOF			1999	30,546	1,535	20	1,535		17,782	30
31	NEW ROOF			2000	3,990	266	15	266		2,727	31
32	A/C UNIT			2000	7,265		8			7,265	32
33	FLOORING			2004	15,971	1,077	15	1,077		7,176	33
34	A/C UNIT			2004	6,378	806	8	806		5,102	34
35	SECURITY ALARM			2004	5,143	644	8	644		4,124	35
36	WASHER			2004	7,887	986	8	986		6,080	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: 01/01/2010 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	Sign	2006	$ 5,593	$ 717	in Years	$ 717	$	$ 3,383	37
38	Water Htr	2006	6,479	823	8	823		3,805	38
39	AC/HTR unit	2006	13,021	868	8	868		3,762	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	$ 38,704		$ 38,704	$	$ 1,461,742	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: 01/01/2010 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	$ 85,183	$ 9,481	$ 9,481	$	8	$ 60,276	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	64,612					64,612	73
74								74
75	TOTALS	$ 149,795	$ 9,481	$ 9,481	$		$ 124,888	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	2007 Dodge Caravan	2007	$ 18,605	$ 3,778	$ 3,778	$	5	$ 11,680	76
77		2008 Dodge Caravan	2008	16,970	3,394	3,394		5	7,919	77
78										78
79										79
80	TOTALS			$ 35,575	$ 7,172	$ 7,172	$		$ 19,599	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)	$ 1,972,440	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 55,357	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 55,357	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,606,229	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: 01/01/2010 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								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.	/2011	$
13.	/2012	$
14.	/2013	$

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: 01/01/2010 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.

Facility Name & ID Number St Ann's Healthcare Center

STATE OF ILLINOIS
0023390 Report Period Beginning: 01/01/2010 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	10-3	hrs	$		$ 100,883	$		$ 100,883	1
2	Licensed Speech and Language Development Therapist	10-3	hrs			10,591			10,591	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10-3	hrs			93,748			93,748	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				39,510		39,510	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Lab	10-3					7,543		7,543	12
13	Other (specify):									13
14	TOTAL			$		$ 205,222	$ 47,053		$ 252,275	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 St Ann's Healthcare Center # 0023390 Report Period Beginning: 01/01/2010 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	$ 122,647	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,612,694		3
4	Supply Inventory (priced at FIFO)	36,665		4
5	Short-Term Investments	302,597		5
6	Prepaid Insurance	7,591		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)**	$ 2,082,194	$	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)	(1,606,229)		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)**	$ 366,211	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,448,405	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 33,535	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	12,971		29
30	Accrued Salaries Payable	79,906		30
31	Accrued Taxes Payable (excluding real estate taxes)	4,805		31
32	Accrued Real Estate Taxes(Sch.IX-B)	1,885		32
33	Accrued Interest Payable	56,656		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)**	$ 189,758	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,888,520		39
40	Mortgage Payable	887,642		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)**	$ 2,776,162	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,965,920	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (517,515)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,448,405	$	48

*(See instructions.)

Facility Name & ID Number St Ann's Healthcare Center **#** 0023390 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (555,462)	1
2	Restatements (describe):		2
3	**reduction of notes to owners**	36,882	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (518,580)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,065	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners		13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 1,065	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)**	$ (517,515)	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	$ 2,799,791	1
2	Discounts and Allowances for all Levels	(335,028)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,464,763	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	382,514	6
7	Oxygen	762	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 383,276	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	3,664	12
13	Barber and Beauty Care	4,238	13
14	Non-Patient Meals	5,562	14
15	Telephone, Television and Radio	118	15
16	Rental of Facility Space		16
17	Sale of Drugs	37,945	17
18	Sale of Supplies to Non-Patients	5,684	18
19	Laboratory	4,080	19
20	Radiology and X-Ray	4,465	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 65,756	23
	D. Non-Operating Revenue		
24	Contributions	6,167	24
25	Interest and Other Investment Income***	5,992	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 12,159	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Rebates	470	28
28a	Misc income	729	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,199	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,927,153	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	707,568	31
32	Health Care	1,329,352	32
33	General Administration	564,533	33
	B. Capital Expense		
34	Ownership	206,528	34
	C. Ancillary Expense		
35	Special Cost Centers	52,953	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)***	$ 2,926,087	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,066	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,066	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 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,639	1,904	$ 42,879	$ 22.52	1
2	Assistant Director of Nursing	1,730	1,794	41,483	23.12	2
3	Registered Nurses	3,530	3,762	83,296	22.14	3
4	Licensed Practical Nurses	16,423	17,391	266,044	15.30	4
5	CNAs & Orderlies	48,465	51,611	483,325	9.36	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,064	2,128	20,772	9.76	9
10	Activity Assistants	1,782	1,982	16,399	8.27	10
11	Social Service Workers	2,001	2,088	25,937	12.42	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	4,000	4,452	60,597	13.61	14
15	Cook Helpers/Assistants	14,540	15,308	125,625	8.21	15
16	Dishwashers					16
17	Maintenance Workers	3,144	3,192	43,105	13.50	17
18	Housekeepers	6,056	6,536	59,743	9.14	18
19	Laundry	5,757	6,301	58,861	9.34	19
20	Administrator	2,088	2,088	52,616	25.20	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,734	4,108	47,416	11.54	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)	116,953	124,645	$ 1,428,098 *	$ 11.46	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	96	$ 8,262	1-3	35
36	Medical Director		6,000	9-3	36
37	Medical Records Consultant	32	2,080	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	96	2,343	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	96	2,250	11-3	44
45	Social Service Consultant		3,605	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	320	$ 24,540		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	68	$ 1,480	10-3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	68	$ 1,480		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Bev Froemming	Administrator		$ 52,616
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 52,616

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
		$
Herman Bodewes	Legal	3,799
WDM Computer Services	Accounting/Coat Reports	26,999
Greer Mgmt	Management	40,000
RDR Mgmt	Management	40,000
Non Allow		(80,000)
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 30,798

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 29,692
Unemployment Compensation Insurance	31,771
FICA Taxes	105,727
Employee Health Insurance	28,279
Employee Meals	7,554
Illinois Municipal Retirement Fund (IMRF)*	
401K Plan	1,590
Drug testing	1,476
TOTAL (agree to Schedule V, line 22, col.8)	$ 206,089

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	441
Health Care Worker Background Check	
(Indicate # of checks performed 35)	1,650
Patient Background Checks 62	
Advertising	20,416
Subscriptions	598
Ill Sec of State	785
Less: Public Relations Expense	( )
Non-allowable advertising	(20,416)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 4,469

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
see attached list	3,474
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,474

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

Facility Name & ID Number St Ann's Healthcare Center # 0023390 Report Period Beginning: 01/01/2010 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? **No**
If YES, give association name and amount.

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

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

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **8yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **21,344** 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. $ **7,554** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **5,562**

(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 of Schedule V? **Yes**

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.