FOR BHF USE

LL1

2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

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: 0041737

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) 229-1560

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 01/01/2011 to 12/31/2011 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 # 0041737 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	11,680	11,169	19,349	42,198	8
9	SNF/PED					9
10	ICF	5,743	5,492		11,235	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,423	16,661	19,349	53,433	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.78%

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 16,111

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: 12/31/11 Fiscal Year: 12/31/11

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

Facility Name & ID Number Provena St. Anne Center # 0041737 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	506,766	78,344	40,859	625,969		625,969		625,969			1
2	Food Purchase		507,388		507,388		507,388	2,535	509,923			2
3	Housekeeping	140,630	29,617		170,247		170,247		170,247			3
4	Laundry	10,731	11,219	141,662	163,612		163,612		163,612			4
5	Heat and Other Utilities			200,139	200,139		200,139	8,071	208,210			5
6	Maintenance	157,492	29,087	82,872	269,451		269,451	114,896	384,347			6
7	Other (specify):* **Pastoral Care**	52,433	1,470	15,420	69,323		69,323	(3,024)	66,299			7
8	**TOTAL General Services**	868,052	657,125	480,952	2,006,129		2,006,129	122,478	2,128,607			8
	B. Health Care and Programs											
9	Medical Director			21,000	21,000		21,000		21,000			9
10	Nursing and Medical Records	4,778,483	388,681	204,621	5,371,785		5,371,785		5,371,785			10
10a	Therapy			1,543,625	1,543,625		1,543,625		1,543,625			10a
11	Activities	133,334	5,888	10,316	149,538		149,538	2,182	151,720			11
12	Social Services	111,448	32	566	112,046		112,046		112,046			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	5,023,265	394,601	1,780,128	7,197,994		7,197,994	2,182	7,200,176			16
	C. General Administration											
17	Administrative	515,964	37,612	1,267,044	1,820,620		1,820,620	(524,164)	1,296,456			17
18	Directors Fees											18
19	Professional Services			14,962	14,962		14,962	73,592	88,554			19
20	Dues, Fees, Subscriptions & Promotions			52,448	52,448		52,448	(14,089)	38,359			20
21	Clerical & General Office Expenses			82,512	82,512		82,512	7,968	90,480			21
22	Employee Benefits & Payroll Taxes			1,654,874	1,654,874		1,654,874	306,879	1,961,753			22
23	Inservice Training & Education			4,105	4,105		4,105	5,024	9,129			23
24	Travel and Seminar			14,935	14,935		14,935	5,506	20,441			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			161,659	161,659		161,659	(653)	161,006			26
27	Other (specify):* **Bad Debt**			83,314	83,314		83,314	(83,314)				27
28	**TOTAL General Administration**	515,964	37,612	3,335,853	3,889,429		3,889,429	(223,251)	3,666,178			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	6,407,281	1,089,338	5,596,933	13,093,552		13,093,552	(98,591)	12,994,961			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 #0041737 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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			418,134	418,134		418,134	94,999	513,133			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							560,473	560,473			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds							25,268	25,268			34
35	Rent-Equipment & Vehicles			12,221	12,221		12,221	4,052	16,273			35
36	Other (specify):*											36
37	**TOTAL Ownership**			430,355	430,355		430,355	684,792	1,115,147			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			1,395,518	1,395,518		1,395,518	(475,055)	920,463			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			98,003	98,003		98,003		98,003			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			1,493,521	1,493,521		1,493,521	(475,055)	1,018,466			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	6,407,281	1,089,338	7,520,809	15,017,428		15,017,428	111,146	15,128,574			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 # 0041737 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	(1,357)	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	14,212	30		9
10	Interest and Other Investment Income	(11,919)	32		10
11	Discounts, Allowances, Rebates & Refunds	(475,055)	39		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(973)	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				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	(83,314)	27		24
25	Fund Raising, Advertising and Promotional	(20,938)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(2,550)	20		28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (581,894)		$	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)	696,064		34
35	Other- Attach Schedule	(3,024)		35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 693,040		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 111,146		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS **Page 5A**

Provena St. Anne Center

ID# **0041737**

Report Period Beginning: **01/01/2011**

Ending: **12/31/2011**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Development Misc	$ (3,024)	7	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**	(3,024)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Provena St. Anne Center # 0041737 **Report Period Beginning:** 01/01/2011 **Ending:** 12/31/2011

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	(1,357)	3,892	0	0	0	0	0	0	0	0	0	2,535	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	8,071	0	0	0	0	0	0	0	0	0	8,071	5
6	Maintenance	0	1,986	112,910	0	0	0	0	0	0	0	0	114,896	6
7	Other (specify):*	(3,024)	0	0	0	0	0	0	0	0	0	0	(3,024)	7
8	**TOTAL General Services**	(4,381)	13,949	112,910	0	0	0	0	0	0	0	0	122,478	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	2,182	0	0	0	0	0	0	0	0	0	2,182	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	2,182	0	0	0	0	0	0	0	0	0	2,182	16
	C. General Administration													
17	Administrative	0	(433,050)	(91,114)	0	0	0	0	0	0	0	0	(524,164)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	41,788	31,804	0	0	0	0	0	0	0	0	73,592	19
20	Fees, Subscriptions & Promotions	(23,488)	9,399	0	0	0	0	0	0	0	0	0	(14,089)	20
21	Clerical & General Office Expenses	(973)	8,941	0	0	0	0	0	0	0	0	0	7,968	21
22	Employee Benefits & Payroll Taxes	0	90,405	216,474	0	0	0	0	0	0	0	0	306,879	22
23	Inservice Training & Education	0	5,024	0	0	0	0	0	0	0	0	0	5,024	23
24	Travel and Seminar	0	5,506	0	0	0	0	0	0	0	0	0	5,506	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	(653)	0	0	0	0	0	0	0	0	0	(653)	26
27	Other (specify):*	(83,314)	0	0	0	0	0	0	0	0	0	0	(83,314)	27
28	**TOTAL General Administration**	(107,775)	(272,640)	157,164	0	0	0	0	0	0	0	0	(223,251)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(112,156)	(256,509)	270,074	0	0	0	0	0	0	0	0	(98,591)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Provena St. Anne Center **#** 0041737 **Report Period Beginning:** 01/01/2011 **Ending:** 12/31/2011

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	14,212	0	80,787	0	0	0	0	0	0	0	0	94,999	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(11,919)	0	572,392	0	0	0	0	0	0	0	0	560,473	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	25,268	0	0	0	0	0	0	0	0	25,268	34
35	Rent-Equipment & Vehicles	0	0	4,052	0	0	0	0	0	0	0	0	4,052	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	2,293	0	682,499	0	0	0	0	0	0	0	0	684,792	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	(475,055)	0	0	0	0	0	0	0	0	0	0	(475,055)	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**	(475,055)	0	0	0	0	0	0	0	0	0	0	(475,055)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(584,918)	(256,509)	952,573	0	0	0	0	0	0	0	0	111,146	45

Facility Name & ID Number Provena St. Anne Center # 0041737 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		Provena Our Lady of Victory	Bourbonnais			
		Provena Pine View Care Center	St. Charles			
		Provena Geneva Care Center	Geneva			
		Provena Cor Mariae Center	Rockford			
		Provena St. Joseph Center	Freeport			
		Provena McAuley Manor	Aurora			
		Provena St. Anne Center	Rockford			

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 Life Connections	100.00%	$ 3,892	$ 3,892	1
2	V	5	Utilities		Provena Life Connections	100.00%	8,071	8,071	2
3	V	6	Maintenance - Other		Provena Life Connections	100.00%	1,986	1,986	3
4	V	11	Activities-Special Events		Provena Life Connections	100.00%	2,182	2,182	4
5	V	17	Admin - Misc. Other	841,896	Provena Life Connections	100.00%	7,585	(834,311)	5
6	V	17	Administrative Salaries		Provena Life Connections	100.00%	401,261	401,261	6
7	V	19	Professional Services		Provena Life Connections	100.00%	41,788	41,788	7
8	V	20	Dues,Subscriptions		Provena Life Connections	100.00%	9,399	9,399	8
9	V	21	Clerical Supplies		Provena Life Connections	100.00%	8,941	8,941	9
10	V	22	Employee Benefits		Provena Life Connections	100.00%	90,405	90,405	10
11	V	23	Education/Conference		Provena Life Connections	100.00%	5,024	5,024	11
12	V	24	Travel		Provena Life Connections	100.00%	5,506	5,506	12
13	V	26	Insurance		Provena Life Connections	100.00%	(653)	(653)	13
14	Total			$ 841,896			$ 585,387	$ * (256,509)	14

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

Facility Name & ID Number Provena St. Anne Center # 0041737 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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 Life Connections	100.00%	$ 4,837	$ 4,837	15
16	V	32	Interest		Provena Life Connections	100.00%	331,735	331,735	16
17	V	34	Rent - Facility		Provena Life Connections	100.00%	25,268	25,268	17
18	V	35	Rent - Equipment		Provena Life Connections	100.00%	4,052	4,052	18
19	V	17	Admin Salaries	190,399	Provena Health Services	100.00%	144,913	(45,486)	19
20	V	22	Employee Benefits		Provena Health Services	100.00%	76,675	76,675	20
21	V	30	Depreciation		Provena Health Services	100.00%	75,950	75,950	21
22	V	19	Admin Consulting,Other		Provena Health Services	100.00%	31,804	31,804	22
23	V	17	Information Systems Salaries	234,749	Provena Health Services	100.00%	62,889	(171,860)	23
24	V	22	Information Systems Benefits		Provena Health Services	100.00%	46,269	46,269	24
25	V	17	Information Systems - Other		Provena Health Services	100.00%	42,603	42,603	25
26	V	17	Admin Salaries		Provena Health Services	100.00%	28,301	28,301	26
27	V	22	Employee Benefits		Provena Health Services	100.00%	37,935	37,935	27
28	V	17	Information Systems Salaries		Provena Health Services	100.00%	55,328	55,328	28
29	V	22	Information Systems Benefits		Provena Health Services	100.00%	55,595	55,595	29
30	V	6	Information Systems - Equip Maint		Provena Health Services	100.00%	112,910	112,910	30
31	V	32	Admin - Interest Expense		Provena Health Services	100.00%	240,657	240,657	31
32	V	39	Ancillary Services - Other	1,395,518	Provena Senior Services Pharmacy	100.00%	1,395,518		32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 1,820,666			$ 2,773,239	$ * 952,573	39

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

Facility Name & ID Number Provena St. Anne Center # 0041737 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

VII. RELATED PARTIES

A. (Continued) **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.**

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Provena Villa Franciscan	Joliet				1
2			Provena Heritage Village	Kankakee				2
3					Provena Clinics	Various	Physician's Clinics	3
4					Provena Fortin Villa	Bourbonnais	Childrens Center	4
5					Provena Fox Knoll	Aurora	Retirement Comm	5
6					Provena Health	Frankfort	Parent Company	6
7					Provena Home Care	Various	Home Health	7
8					Provena Home Equipment		Home Equipment	8
9					Provena Hospice	Various	Hospice	9
10					Provena Hospitals	Various	Hospital	10
11					Provena Laverna Te	Avilla, IN	Independent Livin	11
12					Provena Meadowvie	Kankakee	Supportive Living	12
13					Provena Senior Ser	Mokena	Management Con	13
14					Provena Senior Ser	Kankakee	Pharmacy	14
15					Provena St. Joseph	Freeport	Adult Day Care	15
16					Provena St. Mary's /	Kankakee	Adult Day Care	16
17					Provena St. Vincent	Freeport	Community Living	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

Facility Name & ID Number Provena St. Anne Center # 0041737 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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 # 0041737 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

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 Life Connections
Street Address: 19065 Hickory Creek Drive, Ste 310
City / State / Zip Code: Mokena, IL60448
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	6,979,492	19	$ 32,265	$	841,896	$ 3,892	1
2	5	Utilities	Management Fee Income	6,979,492	19	66,913		841,896	8,071	2
3	6	Maintenance - Other	Management Fee Income	6,979,492	19	16,465		841,896	1,986	3
4	11	Activities-Special Events	Management Fee Income	6,979,492	19	18,086		841,896	2,182	4
5	17	Admin - Misc. Other	Management Fee Income	6,979,492	19	62,879		841,896	7,585	5
6	17	Administrative Salaries	Management Fee Income	6,979,492	19	3,326,538	3,326,538	841,896	401,261	6
7	19	Professional Services	Management Fee Income	6,979,492	19	346,433		841,896	41,788	7
8	20	Dues,Subscriptions	Management Fee Income	6,979,492	19	77,921		841,896	9,399	8
9	21	Clerical Supplies	Management Fee Income	6,979,492	19	74,124		841,896	8,941	9
10	22	Employee Benefits	Management Fee Income	6,979,492	19	749,474		841,896	90,405	10
11	23	Education/Conference	Management Fee Income	6,979,492	19	41,653		841,896	5,024	11
12	24	Travel	Management Fee Income	6,979,492	19	45,642		841,896	5,506	12
13	26	Insurance	Management Fee Income	6,979,492	19	(5,417)		841,896	(653)	13
14	30	Depreciation	Management Fee Income	6,979,492	19	40,099		841,896	4,837	14
15	32	Interest	Management Fee Income	6,979,492	19	2,750,151		841,896	331,735	15
16	34	Rent - Facility	Management Fee Income	6,979,492	19	209,473		841,896	25,268	16
17	35	Rent - Equipment	Management Fee Income	6,979,492	19	33,596		841,896	4,052	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 7,886,295	$ 3,326,538		$ 951,279	25

Facility Name & ID Number Provena St. Anne Center # 0041737 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

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	1,315,329	10	$ 1,001,096	$ 1,001,096	190,399	$ 144,913	1
2	22	Employee Benefits	Operating Expense	1,315,329	10	529,691		190,399	76,675	2
3	30	Depreciation	Operating Expense	1,315,329	10	524,686		190,399	75,950	3
4	34	Rent Facility	Operating Expense	1,315,329	10	219,709		190,399	31,804	4
5	19	Admin Consulting,Other	Operating Expense	1,315,329	10	434,452		190,399	62,889	5
6	17	Information Systems Salaries	Operating Expense	1,621,586	10	319,617	319,617	234,749	46,269	6
7	22	Information Systems Benefits	Operating Expense	1,621,586	10	294,294		234,749	42,603	7
8	17	Information Systems - Other	Operating Expense	1,621,586	10	195,496		234,749	28,301	8
9	17	Admin Salaries	Direct Cost	1,315,329	10	262,066	262,066	190,399	37,935	9
10	17	Information Systems Salaries	Direct Cost	1,621,586	10	382,190	382,190	234,749	55,328	10
11	6	Information Systems - Equip Mair	Direct Cost	1,621,586	10	384,039		234,749	55,595	11
12	19	Admin Consulting,Other	Direct Cost	1,315,329	10	780,014		190,399	112,910	12
13	32	Admin - Interest Expense	Direct Cost	1,315,329	10	1,662,527		190,399	240,657	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					$ 6,989,877	$ 1,964,969		$ 1,011,829	25

Facility Name & ID Number Provena St. Anne Center # 0041737 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

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: 670 North Convent Street
City / State / Zip Code: Bourbonnais, Illinois 60914
Phone Number: (815)936-3644
Fax Number: (815-936-3238

	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			$	$		$ 1,395,518	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					$	$		$ 1,395,518	25

Facility Name & ID Number Provena St. Anne Center # 0041737 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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						$	$			$ 572,392	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 572,392	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$ 572,392	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 **#** 0041737 **Report Period Beginning:** 01/01/2011 **Ending:** 12/31/2011

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 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 2011 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:			
	2006		8
	2007		9
	2008		10
	2009		11
	2010		12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2010	$	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.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Provena St. Anne Center COUNTY Winnebago

FACILITY IDPH LICENSE NUMBER 0041737

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 2010 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 2010.

	(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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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 # 0041737 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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		1984	$ 639,976	1
2					2
3	TOTALS			$ 639,976	3

Facility Name & ID Number Provena St. Anne Center # 0041737 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	$	$ 2,640,697	4
5	59		1993	1993	2,722,251	90,742	30	90,742		1,670,414	5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1986							9
10	Various			1990	34,784	1,122	20	1,122		24,125	10
11	Various			1992	471		10			471	11
12	Various			1993	1,623		10			1,623	12
13	Various			1994	5,000		16			5,000	13
14	Various			1995	40,225	1,271	12	1,271		28,362	14
15	Various			1996	28,449	1,160	5	1,160		28,003	15
16	Various			1997	20,255		5			20,255	16
17	Various			1998	23,000		6			23,000	17
18	Various			1999	6,269		5			6,269	18
19	Various			2000	23,160		6			23,160	19
20	Various			2001	279,756	12,589	10	12,589		219,639	20
21	Various			2002	13,716	586	9	586		11,258	21
22	Various			2003	26,366	2,506	8	2,506		22,606	22
23	Various			2004	38,378	2,956	9	2,956		30,255	23
24	Various			2005	26,107	2,075	12	2,075		18,665	24
25	Various			2006	95,650	7,665	12	7,665		47,147	25
26	Various			2007	171,521	17,010	12	17,010		77,425	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 # 0041737 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	BUILD 25UNITS (ROOM DIVIDERS)	2008	$ 19,250	$ 1,925	10	$ 1,925	$	$ 7,700	37
38	VOICE ANNOUNCEMENTUNIT	2008	4,530	453	10	453		1,812	38
39	ECO FRIENDLY GREENHOUSE	2008	475	19	25	19		67	39
40	ELECTRICAL FOR KITCHEN EQUIP IN NEW	2008	6,376	425	15	425		1,700	40
41	PARTIAL RE-ROOF	2008	29,859	2,986	10	2,986		10,451	41
42	CAFE EQUIPMENT	2008	765	77	10	77		268	42
43	MCQUAY PTAC UNITS	2008	10,900	727	15	727		2,543	43
44	STAIN EXTERIOR BOARD AND TRIM	2008	3,650	521	7	521		1,825	44
45	(11) THERMO WINDOWS	2008	7,700	385	20	385		1,348	45
46	NURSE CALL SYSTEM	2008	61,170	6,117	10	6,117		21,410	46
47	FIRE DAMPERS	2008	4,101	410	10	410		1,435	47
48	CARESENSECHAIR MONITORINGSYSTEM/BE	2008	9,706	971	10	971		3,397	48
49	SEALCOATING OF PARKING LOT	2008	2,781	348	8	348		1,217	49
50	SMOKE DETECTORS	2008	6,920	692	10	692		2,422	50
51									51
52	REPIPE DRAIN AND CONTROL VALVES	2009	2,980	199	15	199		497	52
53	PARKING LOT REPAIRS/SEALCOATING	2009	14,252	2,036	7	2,036		5,090	53
54	DOOR CLOSURE & SMOKE DETECTORS	2009	19,361	1,936	10	1,936		4,840	54
55	UPGRADESTO ANSUL SYSTEM INDIETARY	2009	3,334	333	10	333		833	55
56									56
57	INSTALL WATER LINES IN CAF	2010	6,420	642	10	642		963	57
58	GENERATORS	2010	10,824	2,165	5	2,165		3,247	58
59	WALL, TILE, AND SINKS	2010	10,686	1,069	10	1,069		1,603	59
60	SPA UNITS	2010	55,425	3,695	15	3,695		5,543	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)		$ 7,365,353	$ 268,294		$ 268,294	$	$ 4,978,584	70

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

Facility Name & ID Number Provena St. Anne Center # 0041737 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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		$ 7,365,353	$ 268,294		$ 268,294	$	$ 4,978,584	1
2									2
3	WATER HEATER SOUTHBASEMENT	2011	5,512	276	10	552	276	276	3
4	ROOFTOP CONDENSINGUNIT	2011	32,862	1,095	15	2,190	1,095	1,095	4
5	PTAC UNITS QTY 10	2011	5,835	292	10	584	292	292	5
6	7/12 @ 1743Senior Services	2011	3,989	100	20	200	100	100	6
7	SPRINKLERHEAD REPLACEMENTS	2011	2,940	294	5	588	294	294	7
8	AIR HANDLER SOUTH BASEMENT	2011	19,000	475	20	950	475	475	8
9	PARKING LOT REPAIRS	2011	25,885	1,618	8	3,236	1,618	1,618	9
10	TILE FORADMIN OFFICE	2011	13,853	693	10	1,386	693	693	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)		$ 7,475,228	$ 273,136		$ 277,980	$ 4,844	$ 4,983,426	34

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

Facility Name & ID Number Provena St. Anne Center # 0041737 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	$ 1,386,550	$ 135,630	$ 135,630	$	11	$ 674,043	71
72	Current Year Purchases	130,983	8,659	17,318	8,659	9	8,659	72
73	Fully Depreciated Assets	330,937				6	330,937	73
74	Home Office Allocation		80,787	80,787				74
75	TOTALS	$ 1,848,470	$ 225,076	$ 233,735	$ 8,659		$ 1,013,639	75

D. Vehicle Costs. (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	1998	$ 43,500	$	$	$	5	$ 43,500	76
77	Plant Engineering	F150 FORD W/SNOWPLOW	1999	23,172				3	23,172	77
78	Plant Engineering	AXLE HOUSIN	2011	4,256	709	1,418	709	3	709	78
79										79
80	TOTALS			$ 70,928	$ 709	$ 1,418	$ 709		$ 67,381	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)	$ 10,034,602	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 498,921	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 513,133	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 14,212	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 6,064,446	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 # 0041737 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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				25,268			5
6								6
7	TOTAL				$ 25,268 **			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.	/2012	$
13.	/2013	$
14.	/2014	$

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: $ 209,425 Description: Nursing $188,480; Activities $129; Plant Eng $4,544; Administration $12,220; Home Office $4,052
(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 # 0041737 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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 Provena St. Anne Center | STATE OF ILLINOIS # 0041737 | Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	$	10,052	$ 690,138	$	10,052	$ 690,138	1
2	Licensed Speech and Language Development Therapist	10a,3	hrs		1,083	80,477		1,083	80,477	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a,3	hrs		10,983	773,011		10,983	773,011	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				1,395,518		1,395,518	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			$	22,117	$ 1,543,626	$ 1,395,518	22,117	$ 2,939,144	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 # 0041737 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2011 (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	$ 9,921,439	$	1
2	Cash-Patient Deposits	94,756		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	15,932,837		3
4	Supply Inventory (priced at)	788,723		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	202,376		7
8	Accounts Receivable (owners or related parties)	135,366		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 27,075,497	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	8,348,207		12
13	Land	6,027,432		13
14	Buildings, at Historical Cost	82,802,332		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	19,392,931		16
17	Accumulated Depreciation (book methods)	(58,282,720)		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)**	$ 58,288,182	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 85,363,679	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 5,213,946	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,164,816		28
29	Short-Term Notes Payable	65,040		29
30	Accrued Salaries Payable	3,383,504		30
31	Accrued Taxes Payable (excluding real estate taxes)	136,208		31
32	Accrued Real Estate Taxes(Sch.IX-B)	1,389,718		32
33	Accrued Interest Payable	10,520		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to Related Party	983,226		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 12,346,978	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,037,972		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	396,894		42
	Other Long-Term Liabilities(specify):			
43	Conditional Asset Retirement	438,744		43
44	Deferred Lease Payable	23,814		44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,897,424	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 14,244,402	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 71,119,277	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 85,363,679	$	48

*(See instructions.)

Facility Name & ID Number Provena St. Anne Center # 0041737 **Report Period Beginning:** 01/01/2011 **Ending:** 12/31/2011

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 74,355,616	1
2	Restatements (describe):		2
3	**Transfer to Affiliates**	(8,169,570)	3
4	**Adj. To reconcile consolidated equity & consolidated income**	4,058,672	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 70,244,718	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	791,378	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	226,484	11
12	Expenditures for Specific Purposes	(143,303)	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)**	$ 874,559	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)**	$ 71,119,277	24 *

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

Facility Name & ID Number Provena St. Anne Center # 0041737 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	$ 11,067,195	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 11,067,195	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,753,179	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,753,179	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	98,157	12
13	Barber and Beauty Care	3,858	13
14	Non-Patient Meals	1,357	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,331,341	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	14,011	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,448,724	23
	D. Non-Operating Revenue		
24	Contributions	44,621	24
25	Interest and Other Investment Income***	11,919	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 56,540	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Purchase Rebates	475,055	28
28a	Misc. Income/Gain/Loss SOFA	8,113	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 483,168	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 15,808,806	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,006,129	31
32	Health Care	7,197,994	32
33	General Administration	3,889,429	33
	B. Capital Expense		
34	Ownership	430,355	34
	C. Ancillary Expense		
35	Special Cost Centers	1,395,518	35
36	Provider Participation Fee	98,003	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 15,017,428	40
41	**Income before Income Taxes (line 30 minus line 40)****	791,378	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 791,378	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.**

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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	1,704	1,924	$ 88,790	$ 46.15	1
2	Assistant Director of Nursing	1,696	2,080	72,116	34.67	2
3	Registered Nurses	46,388	53,049	1,555,554	29.32	3
4	Licensed Practical Nurses	40,671	48,473	1,267,268	26.14	4
5	CNAs & Orderlies	112,049	123,339	1,522,839	12.35	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,593	8,516	109,280	12.83	8
9	Activity Director	1,852	2,056	36,914	17.95	9
10	Activity Assistants	8,135	8,656	97,724	11.29	10
11	Social Service Workers	5,634	6,289	111,298	17.70	11
12	Dietician	1,436	1,543	35,040	22.71	12
13	Food Service Supervisor	4,322	4,765	88,759	18.63	13
14	Head Cook					14
15	Cook Helpers/Assistants	38,457	41,325	402,017	9.73	15
16	Dishwashers					16
17	Maintenance Workers	8,432	9,255	159,498	17.23	17
18	Housekeepers	13,572	14,923	140,554	9.42	18
19	Laundry	1,132	1,153	9,637	8.36	19
20	Administrator	1,836	2,080	93,015	44.72	20
21	Assistant Administrator	1,720	2,080	56,858	27.34	21
22	Other Administrative	8,181	9,015	145,056	16.09	22
23	Office Manager	1,952	2,080	45,294	21.78	23
24	Clerical	7,537	8,969	143,622	16.01	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	5,973	6,249	175,741	28.12	32
33	Other(specify) Pastoral Care	2,271	2,479	50,407	20.33	33
34	TOTAL (lines 1 - 33)	322,543	360,298	$ 6,407,281 *	$ 17.78	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	601	$ 36,938	1,3	35
36	Medical Director	140	21,000	9,3	36
37	Medical Records Consultant	33	2,306	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	69	3,362	11,3	44
45	Social Service Consultant	6	372	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	849	$ 63,978		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 # 0041737 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Janelle Chadwick	Admnistrator	0	$ 93,015
Administrative Staff	Asst Administrator	0	56,858
Administrative Staff	Office Manager	0	45,294
Administrative Staff	Human Resources	0	46,226
Administrative Staff	Receptionist	0	59,487
Administrative Staff	Admin Asst	0	39,343
Administrative Staff	Admissions	0	175,741
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 515,964

B. Administrative - Other

Description	Amount
Corp Service Fee	$ 190,399
Corp Service IS Fee	234,749
Mgmt Fee	544,200
Mgmt Fee Interest	297,696
TOTAL (agree to Schedule V, line 17, col. 3)	$ 1,267,044
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Legal Expense	Various	$ 3,485
Survey & Analytical Tools	Various	4,262
Transporation Service	Various	4,588
Collection Fees	Various	2,436
Shredding/Storage	Various	843
Living Design	Various	
Outsourced Services	Various	1,205
Audit Expense	Various	(1,856)
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 14,962

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 182,442
Unemployment Compensation Insurance	47,995
FICA Taxes	453,008
Employee Health Insurance	685,587
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Life Insurance	24,519
Pension	212,394
Employee Recognition	4,411
Executive Benefits	7,956
Employee Screening	36,563
Home Office Allocation	306,879
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,961,754

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 41)	
Patient Background Checks 654	
Employee Recruitment	3,008
Dues & Subscription	20,914
Advertising & Public Relations	28,526
Home Office Allocation	9,399
Less: Public Relations Expense	( )
Non-allowable advertising	(20,938)
Yellow page advertising	(2,550)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 38,359

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 9,830
In-State Travel	5,105
Seminar Expense	
Home Office Allocation	5,506
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 20,441

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Provena St. Anne Center # 0041737 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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 # 0041737 **Report Period Beginning:** 01/01/2011 **Ending:** 12/31/2011

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 Services Network $9,547.25**

(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. $ **64,136** 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. $ **98,003**
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. $ **1,357**

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

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

(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.