FOR BHF USE

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2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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: Presence 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 C 3			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Lynda M. 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 01/01/2012 to 12/31/2012 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 Presence St Anne Center # 0041737 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	43,920	1
2		Skilled Pediatric (SNF/PED)			2
3	59	Intermediate (ICF)	59	21,594	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	179	TOTALS	179	65,514	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	13,297	11,428	19,918	44,643	8
9	SNF/PED					9
10	ICF	6,550	5,629		12,179	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	19,847	17,057	19,918	56,822	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.73%

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 10/06/1986

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 10/06/1986 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 16,285

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

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

Facility Name & ID Number Presence St Anne Center # 0041737 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY 9	10	
	A. General Services											
1	Dietary	554,960	89,007	15,099	659,066		659,066		659,066			1
2	Food Purchase		541,503		541,503		541,503	2,178	543,681			2
3	Housekeeping	134,598	28,226		162,824		162,824		162,824			3
4	Laundry	9,226	14,084	154,012	177,322		177,322		177,322			4
5	Heat and Other Utilities			193,683	193,683		193,683	7,153	200,836			5
6	Maintenance	168,277	38,923	82,100	289,300		289,300	114,647	403,947			6
7	Other (specify):* Pastoral Care	52,947	1,039	13,994	67,980		67,980	(1,668)	66,312			7
8	**TOTAL General Services**	920,008	712,782	458,888	2,091,678		2,091,678	122,310	2,213,988			8
	B. Health Care and Programs											
9	Medical Director			21,000	21,000		21,000		21,000			9
10	Nursing and Medical Records	5,006,175	462,540	201,941	5,670,656		5,670,656		5,670,656			10
10a	Therapy			1,739,818	1,739,818		1,739,818		1,739,818			10a
11	Activities	135,022	5,805	11,225	152,052		152,052	5,382	157,434			11
12	Social Services	113,690		189	113,879		113,879		113,879			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	5,254,887	468,345	1,974,173	7,697,405		7,697,405	5,382	7,702,787			16
	C. General Administration											
17	Administrative	538,316	33,568	1,303,800	1,875,684		1,875,684	(565,441)	1,310,243			17
18	Directors Fees											18
19	Professional Services			31,785	31,785		31,785	71,281	103,066			19
20	Dues, Fees, Subscriptions & Promotions			37,246	37,246		37,246	(8,795)	28,451			20
21	Clerical & General Office Expenses			85,911	85,911		85,911	6,066	91,977			21
22	Employee Benefits & Payroll Taxes			1,594,237	1,594,237		1,594,237	308,758	1,902,995			22
23	Inservice Training & Education			2,897	2,897		2,897	1,172	4,069			23
24	Travel and Seminar			7,079	7,079		7,079	7,029	14,108			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			247,458	247,458		247,458	(801)	246,657			26
27	Other (specify):*											27
28	**TOTAL General Administration**	538,316	33,568	3,310,413	3,882,297		3,882,297	(180,731)	3,701,566			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	6,713,211	1,214,695	5,743,474	13,671,380		13,671,380	(53,039)	13,618,341			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 Presence St Anne Center #0041737 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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			419,927	419,927		419,927	82,111	502,038			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							345,372	345,372			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds							37,073	37,073			34
35	Rent-Equipment & Vehicles			16,609	16,609		16,609	2,348	18,957			35
36	Other (specify):*											36
37	**TOTAL Ownership**			436,536	436,536		436,536	466,904	903,440			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			1,573,842	1,573,842		1,573,842	(659,112)	914,730			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			453,713	453,713		453,713		453,713			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			2,027,555	2,027,555		2,027,555	(659,112)	1,368,443			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	6,713,211	1,214,695	8,207,565	16,135,471		16,135,471	(245,247)	15,890,224			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 Presence St Anne Center # 0041737 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	(2,410)	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	3,408	30		9
10	Interest and Other Investment Income	(11,676)	32		10
11	Discounts, Allowances, Rebates & Refunds	(659,112)	39		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,040)	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	(715)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(18,477)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(752)	20		28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (690,774)		$	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)	447,195		34
35	Other- Attach Schedule	(1,668)		35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 445,527		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (245,247)		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

Presence St Anne Center

ID# 0041737

Report Period Beginning: 01/01/2012

Ending: 12/31/2012

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Development Misc	$ (1,668)	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**	(1,668)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Presence St Anne Center # 0041737 **Report Period Beginning:** 01/01/2012 **Ending:** 12/31/2012

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	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,410)	4,588	0	0	0	0	0	0	0	0	0	2,178	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	7,153	0	0	0	0	0	0	0	0	0	7,153	5
6	Maintenance	0	2,686	111,961	0	0	0	0	0	0	0	0	114,647	6
7	Other (specify):*	(1,668)	0	0	0	0	0	0	0	0	0	0	(1,668)	7
8	**TOTAL General Services**	(4,078)	14,427	111,961	0	0	0	0	0	0	0	0	122,310	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	5,382	0	0	0	0	0	0	0	0	0	5,382	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	5,382	0	0	0	0	0	0	0	0	0	5,382	16
	C. General Administration													
17	Administrative	0	(473,434)	(92,007)	0	0	0	0	0	0	0	0	(565,441)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	40,141	31,140	0	0	0	0	0	0	0	0	71,281	19
20	Fees, Subscriptions & Promotions	(19,229)	10,434	0	0	0	0	0	0	0	0	0	(8,795)	20
21	Clerical & General Office Expenses	(1,755)	7,821	0	0	0	0	0	0	0	0	0	6,066	21
22	Employee Benefits & Payroll Taxes	0	74,430	234,328	0	0	0	0	0	0	0	0	308,758	22
23	Inservice Training & Education	0	1,172	0	0	0	0	0	0	0	0	0	1,172	23
24	Travel and Seminar	0	7,029	0	0	0	0	0	0	0	0	0	7,029	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	(801)	0	0	0	0	0	0	0	0	0	(801)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(20,984)	(333,208)	173,461	0	0	0	0	0	0	0	0	(180,731)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(25,062)	(313,399)	285,422	0	0	0	0	0	0	0	0	(53,039)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Presence St Anne Center # 0041737 **Report Period Beginning:** 01/01/2012 **Ending:** 12/31/2012

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	3,408	0	78,703	0	0	0	0	0	0	0	0	82,111	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(11,676)	0	357,048	0	0	0	0	0	0	0	0	345,372	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	37,073	0	0	0	0	0	0	0	0	37,073	34
35	Rent-Equipment & Vehicles	0	0	2,348	0	0	0	0	0	0	0	0	2,348	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(8,268)	0	475,172	0	0	0	0	0	0	0	0	466,904	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	(659,112)	0	0	0	0	0	0	0	0	0	0	(659,112)	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**	(659,112)	0	0	0	0	0	0	0	0	0	0	(659,112)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(692,442)	(313,399)	760,594	0	0	0	0	0	0	0	0	(245,247)	45

Facility Name & ID Number Presence St Anne Center # 0041737 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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
		Presence Our Lady of Victory	Bourbonnais	Presence Service C	Various	Physician's Clinics
		Presence Pine View Care Center	St. Charles	Presence Fortin Villa	Bourbonnais	Childrens Center
		Presence Cor Mariae Center	Rockford	Presence Fox Knoll	Aurora	Retirement Comm
		Presence St. Joseph Center	Freeport	Presence Health	Frankfort	Parent Company
		Presence McAuley Manor	Aurora	Presence Home Ca	Various	Home Health
		Presence St. Anne Center	Rockford	Presence Care @ H	Various	Home Equipment
		Presence Villa Franciscan	Joliet	Presence Hospice	Various	Hospice

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	$	Presence Life Connections	100.00%	$ 4,588	$ 4,588	1
2	V	5	Utilities		Presence Life Connections	100.00%	7,153	7,153	2
3	V	6	Maintenance - Other		Presence Life Connections	100.00%	2,686	2,686	3
4	V	11	Activities-Special Events		Presence Life Connections	100.00%	5,382	5,382	4
5	V	17	Admin - Misc. Other	884,400	Presence Life Connections	100.00%	15,992	(868,408)	5
6	V	17	Administrative Salaries		Presence Life Connections	100.00%	394,974	394,974	6
7	V	19	Professional Services		Presence Life Connections	100.00%	40,141	40,141	7
8	V	20	Dues,Subscriptions		Presence Life Connections	100.00%	10,434	10,434	8
9	V	21	Clerical Supplies		Presence Life Connections	100.00%	7,821	7,821	9
10	V	22	Employee Benefits		Presence Life Connections	100.00%	74,430	74,430	10
11	V	23	Education/Conference		Presence Life Connections	100.00%	1,172	1,172	11
12	V	24	Travel		Presence Life Connections	100.00%	7,029	7,029	12
13	V	26	Insurance		Presence Life Connections	100.00%	(801)	(801)	13
14	Total			$ 884,400			$ 571,001	$ * (313,399)	14

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

Facility Name & ID Number Presence St Anne Center # 0041737 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	$	Presence Life Connections	100.00%	$ 3,793	$ 3,793	15
16	V	32	Interest		Presence Life Connections	100.00%	118,413	118,413	16
17	V	34	Rent - Facility		Presence Life Connections	100.00%	37,073	37,073	17
18	V	35	Rent - Equipment		Presence Life Connections	100.00%	2,348	2,348	18
19	V	17	Admin Salaries	134,400	Presence Health	100.00%	142,345	7,945	19
20	V	22	Employee Benefits		Presence Health	100.00%	75,211	75,211	20
21	V	30	Depreciation		Presence Health	100.00%	74,910	74,910	21
22	V	19	Admin Consulting,Other		Presence Health	100.00%	31,140	31,140	22
23	V	17	Information Systems Salaries	285,000	Presence Health	100.00%	59,001	(225,999)	23
24	V	22	Information Systems Benefits		Presence Health	100.00%	45,913	45,913	24
25	V	17	Information Systems - Other		Presence Health	100.00%	42,134	42,134	25
26	V	17	Admin Salaries		Presence Health	100.00%	29,011	29,011	26
27	V	22	Employee Benefits		Presence Health	100.00%	37,616	37,616	27
28	V	17	Information Systems Salaries		Presence Health	100.00%	54,902	54,902	28
29	V	22	Information Systems Benefits		Presence Health	100.00%	75,588	75,588	29
30	V	6	Information Systems - Equip Maint		Presence Health	100.00%	111,961	111,961	30
31	V	32	Admin - Interest Expense		Presence Health	100.00%	238,635	238,635	31
32	V	39	Ancillary Services - Other	1,573,842	Presence Senior Services Pharmacy	100.00%	1,573,842		32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 1,993,242			$ 2,753,836	$ * 760,594	39

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

Facility Name & ID Number Presence St Anne Center # 0041737 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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			Presence Heritage Village	Kankakee	Presence Hospitals	Various	Hospital	1
2			Presence Ballard Nursing Center	Des Plaines	Laverna Terrace Housin	Avilla, IN	Independent Living	2
3			Presence Maryhaven Nursing & Rehab Center	Glenview	Presence Heritage Lodg	Kankakee	Supportive Living	3
4			Presence Nazarethville	Des Plaines	Presence Life Connectic	Mokena	Management Compar	4
5			Presence Resurrection Life Center	Chicago	Presence Senior Service	Kankakee	Pharmacy	5
6			Presence Resurrection Nursing & Rehab Center	Park Ridge	Presence St. Joseph Adu	Freeport	Adult Day Care	6
7			Presence St Andrew Life Center	Niles	Presence Heritage Day I	Kankakee	Adult Day Care	7
8			Presence St Benedict Nursing & Rehab Center	Niles	Presence St. Vincent	Freeport	Community Living	8
9			Presence Villa Scalabrini Nursing & Rehab Cen	Northlake	Presence Behavioral He	Broadview	Parent	9
10					Presence Holy Family	Des Plaines	Hospital	10
11					Presence Bethlehem W	LaGrange Park	Independent Living	11
12					Presence Our Lady of	Chicago	Hospital	12
13					Presence Casa San Car	Northlake	Independent Living	13
14					Presence Ambulatory S	Various	Parent	14
15					Resurrection Developr	Chicago	Parent	15
16					Presence Healthcare S	Various	Parent	16
17					Presence Health Care	Various	Physicians	17
18					Presence Home Care S	Various	Home Health	18
19					Presence Resurrection	Chicago	Hospital	19
20					Resurrection Ministries of New York		Nursing Home	20
21					Resurrection Services	Des Plaines	Parent	21
22					Presence Saint Francis	Evanston	Hospital	22
23					Presence Saint Joseph	Chicago	Hospital	23
24					Presence Saints Mary	Chicago	Hospital	24
25					Resurrection Retireme	Chicago	Independent Living	25
26					Resurrection Universit	Chicago	College	26
27					Presence Health Partn	Various	Parent	27
28					Presence Properties PI	Frankfort	Parent	28
29					Presence Ventures, Inc	Frankfort	Parent	29
30					Presence Heritage Esta	Kankakee	Independent Living	30

Facility Name & ID Number Presence St Anne Center # 0041737 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		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 Presence St Anne Center # 0041737 Report Period Beginning: 01/01/2012 Ending: 2/31/2012

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: Presence Life Connections
Street Address: 19065 Hickory Creek Drive, Ste 310
City / State / Zip Code: Mokena, IL 60448
Phone Number: (708)478-7900
Fax Number: (708)478-5387

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	Food	Management Fee Income	7,895,880	23	$ 40,958	$	884,400	$ 4,588	1
2	5	Utilities	Management Fee Income	7,895,880	23	63,861		884,400	7,153	2
3	6	Maintenance - Other	Management Fee Income	7,895,880	23	23,977		884,400	2,686	3
4	11	Activities-Special Events	Management Fee Income	7,895,880	23	48,049		884,400	5,382	4
5	17	Admin - Misc. Other	Management Fee Income	7,895,880	23	142,773		884,400	15,992	5
6	17	Administrative Salaries	Management Fee Income	7,895,880	23	3,526,307	3,526,307	884,400	394,974	6
7	19	Professional Services	Management Fee Income	7,895,880	23	358,375		884,400	40,141	7
8	20	Dues,Subscriptions	Management Fee Income	7,895,880	23	93,150		884,400	10,434	8
9	21	Clerical Supplies	Management Fee Income	7,895,880	23	69,822		884,400	7,821	9
10	22	Employee Benefits	Management Fee Income	7,895,880	23	664,511		884,400	74,430	10
11	23	Education/Conference	Management Fee Income	7,895,880	23	10,463		884,400	1,172	11
12	24	Travel	Management Fee Income	7,895,880	23	62,753		884,400	7,029	12
13	26	Insurance	Management Fee Income	7,895,880	23	(7,150)		884,400	(801)	13
14	30	Depreciation	Management Fee Income	7,895,880	23	33,862		884,400	3,793	14
15	32	Interest	Management Fee Income	7,895,880	23	1,057,182		884,400	118,413	15
16	34	Rent - Facility	Management Fee Income	7,895,880	23	330,990		884,400	37,073	16
17	35	Rent - Equipment	Management Fee Income	7,895,880	23	20,962		884,400	2,348	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 6,540,845	$ 3,526,307		$ 732,628	25

Facility Name & ID Number Presence St Anne Center # 0041737 Report Period Beginning: 01/01/2012 Ending: 2/31/2012

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: Presence Health
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	936,340	10	$ 991,694	$ 991,694	134,400	$ 142,345	1
2	22	Employee Benefits	Operating Expense	936,340	10	523,983		134,400	75,211	2
3	30	Depreciation	Operating Expense	936,340	10	521,887		134,400	74,910	3
4	34	Rent Facility	Operating Expense	936,340	10	216,946		134,400	31,140	4
5	19	Admin Consulting,Other	Operating Expense	936,340	10	411,047		134,400	59,001	5
6	17	Information Systems Salaries	Operating Expense	1,983,972	10	319,617	319,617	285,000	45,913	6
7	22	Information Systems Benefits	Operating Expense	1,983,972	10	293,305		285,000	42,134	7
8	17	Information Systems - Other	Operating Expense	1,983,972	10	201,957		285,000	29,011	8
9	17	Admin Salaries	Direct Cost	936,340	10	262,066	262,066	134,400	37,616	9
10	17	Information Systems Salaries	Direct Cost	1,983,972	10	382,190	382,190	285,000	54,902	10
11	6	Information Systems - Equip Mai	Direct Cost	1,983,972	10	526,191		285,000	75,588	11
12	19	Admin Consulting,Other	Direct Cost	936,340	10	780,014		134,400	111,961	12
13	32	Admin - Interest Expense	Direct Cost	936,340	10	1,662,527		134,400	238,635	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					$ 7,093,424	$ 1,955,567		$ 1,018,367	25

Facility Name & ID Number Presence St Anne Center # 0041737 Report Period Beginning: 01/01/2012 Ending: 2/31/2012

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: Presence 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			$	$		$ 1,573,842	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					$	$		$ 1,573,842	25

Facility Name & ID Number Presence St Anne Center # 0041737 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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						$	$			$ 357,048	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 357,048	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$ 357,048	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 Presence St Anne Center # 0041737 **Report Period Beginning:** 01/01/2012 **Ending:** 12/31/2012

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 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 2012 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:		
	2007	8
	2008	9
	2009	10
	2010	11
	2011	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	$	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.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Presence 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 2011 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 2011.

	(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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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 Presence St Anne Center # 0041737 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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 Presence St Anne Center # 0041737 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	$	$ 2,741,180	4
5	59		1993	1993	2,722,251	90,742	30	90,742		1,761,155	5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1986							9
10	Various			1987							10
11	Various			1988							11
12	Various			1989							12
13	Various			1990	34,784	1,122	20	1,122		25,247	13
14	Various			1991							14
15	Various			1992	471		10			471	15
16	Various			1993	1,623		16			1,623	16
17	Various			1994	5,000		10			5,000	17
18	Various			1995	40,225	1,271	16	1,271		29,633	18
19	Various			1996	28,449	446	12	446		28,449	19
20	Various			1997	20,255		5			20,255	20
21	Various			1998	23,000		5			23,000	21
22	Various			1999	6,269		6			6,269	22
23	Various			2000	23,160		5			23,160	23
24	Various			2001	279,756	6,328	6	6,328		225,967	24
25	Various			2002	13,716	521	10	521		11,779	25
26	Various			2003	26,366	2,506	9	2,506		25,112	26
27	Various			2004	38,378	2,956	8	2,956		33,211	27
28	Various			2005	26,107	1,971	9	1,971		20,636	28
29	Various			2006	95,650	6,801	12	6,801		53,948	29
30	Various			2007	171,521	15,025	12	15,025		92,451	30
31	Various			2008	168,183	16,055	12	16,055		73,649	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 Presence St Anne Center # 0041737 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	REPIPE DRAIN AND CONTROL VALVES	2009	$ 2980	$ 199	15	$ 199	$	$ 695	37
38	PARKING LOT REPAIRS/SEALCOATING	2009	14252	2036	7	2036		7126	38
39	DOOR CLOSURE & SMOKE DETECTORS	2009	19361	1936	10	1936		6776	39
40	UPGRADES TO ANSUL SYSTEM IN DIETARY DEPARTMENT	2009	3334	333	10	333		1167	40
41									41
42									42
43	INSTALL WATER LINES IN CAF	2010	6420	642	10	642		1605	43
44	GENERATORS	2010	10824	2165	5	2165		5412	44
45	WALL, TILE, AND SINKS	2010	10686	1069	10	1069		2672	45
46	SPA UNITS	2010	55425	3695	15	3695		9238	46
47									47
48									48
49	WATER HEATER SOUTH BASEMENT	2011	5512	551	10	551		827	49
50	ROOFTOP CONDENSING UNIT	2011	32862	2191	15	2191		3286	50
51	PTAC UNITS QTY 10	2011	5835	583	10	583		875	51
52	NEW BATHROOM FIXTURES	2011	3989	199	20	199		299	52
53	NEW SPRINKLERHEADS	2011	2940	588	5	588		882	53
54	AIR HANDLER SOUTH BASEMENT	2011	19000	950	20	950		1425	54
55	TILE FOR ADMIN OFFICE	2011	13853	1385	10	1385		2078	55
56	PARKING LOT REPAIRS	2011	25885	3236	8	3236		4853	56
57									57
58									58
59	BRANCH LINES&32 SPRINKLER HEADS. REPLACE PIPE&A	2012	60212	1204	25	2409	**1,204**	1204	59
60	CARPET IN SOUTHWEST F-WING & UNIT #56	2012	2935	294	5	587	**294**	294	60
61	HVAC WORK FOR LIBRARY & SOUTH UNIT	2012	10446	1045	5	2089	**1,045**	1045	61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	**TOTAL (lines 4 thru 69)**		**$ 7,548,821**	**$ 270,528**		**$ 273,070**	**$ 2,542**	**$ 5,253,954**	70

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

Facility Name & ID Number Presence St Anne Center # 0041737 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	$ 1,462,588	$ 147,114	$ 147,114	$	11	$ 762,874	71
72	Current Year Purchases	16,596	866	1,732	866	10	866	72
73	Fully Depreciated Assets	392,791				6	386,322	73
74	Home Office Allocation		78,703	78,703				74
75	TOTALS	$ 1,871,975	$ 226,683	$ 227,549	$ 866		$ 1,150,062	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	MINI-VAN (LOU BACHRODT C	1998	$ 43,500	$ -	$ -	$	5	$ 43,500	76
77	PLANT ENGINEERING	F150 FORD WITH SNOWPLOW	1999	23,172	-	-		3	23,172	77
78	PLANT ENGINEERING	REMOVAL & REPLACEMENT C	2011	4,256	1,419	1,419		3	2,128	78
79										79
80	TOTALS			$ 70,928	$ 1,419	$ 1,419	$		$ 68,800	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)	$ 10,131,700	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 498,629	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 502,038	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 3,408	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 6,472,815	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 Presence St Anne Center # 0041737 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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				37,073			5
6								6
7	TOTAL				$ 37,073 **			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.	/2013	$
13.	/2014	$
14.	/2015	$

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: $ 207,588 Description: Nursing $186,037; Plant Engineering $2,009; Andinistration $17,194; Home Office $2,348
(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 Presence St Anne Center # 0041737 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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 Presence St Anne Center # 0041737 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a,3	hrs	$	14,020	$ 788,739	$	14,020	$ 788,739	1
2	Licensed Speech and Language Development Therapist	10a,3	hrs		1,392	83,095		1,392	83,095	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a,3	hrs		14,919	867,984		14,919	867,984	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				1,573,842		1,573,842	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			$	30,331	$ 1,739,818	$ 1,573,842	30,331	$ 3,313,660	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 Presence St Anne Center # 0041737 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2012 (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	$ 13,086,787	$	1
2	Cash-Patient Deposits	87,303		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	19,569,971		3
4	Supply Inventory (priced at)	652,763		4
5	Short-Term Investments			5
6	Prepaid Insurance	1,531		6
7	Other Prepaid Expenses	114,653		7
8	Accounts Receivable (owners or related parties)	152,567		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 33,665,575	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	8,629,961		12
13	Land	6,033,932		13
14	Buildings, at Historical Cost	86,623,224		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	19,565,514		16
17	Accumulated Depreciation (book methods)	(62,295,376)		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 (spe **Deferred Comp**	418,087		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 58,975,342	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 92,640,917	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 6,316,095	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,097,772		28
29	Short-Term Notes Payable	69,804		29
30	Accrued Salaries Payable	3,738,678		30
31	Accrued Taxes Payable (excluding real estate taxes)	160,341		31
32	Accrued Real Estate Taxes(Sch.IX-B)	1,523,338		32
33	Accrued Interest Payable	9,580		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	**Due to Related Party**	819,992		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 13,735,600	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	969,488		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	418,087		42
	Other Long-Term Liabilities(specify):			
43	**Conditional Asset Retirement**	438,744		43
44	**Deferred Lease Payable**	28,912		44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,855,231	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 15,590,831	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 77,050,086	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 92,640,917	$	48

***(See instructions.)**

Facility Name & ID Number Presence St Anne Center # 0041737 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 71,119,277	1	
2	Restatements (describe):		2	
3	**Transfer to Affiliates**	(967,209)	3	
4	**Adj. To reconcile consolidated equity & consolidated income**	3,364,765	4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 73,516,833	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	580,534	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants	3,067,950	11	
12	Expenditures for Specific Purposes	(115,231)	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)**	$ 3,533,253	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)**	$ 77,050,086	24	*

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

Facility Name & ID Number Presence St Anne Center # 0041737 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 10,902,373	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 10,902,373	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,463,562	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 3,463,562	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		12
13	Barber and Beauty Care	4,550	13
14	Non-Patient Meals	108,329	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,489,815	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	26,121	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,628,815	23
	D. Non-Operating Revenue		
24	Contributions	18,897	24
25	Interest and Other Investment Income***	11,676	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 30,573	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Purchase Rebates	659,112	28
28a	Misc Income/Gain Loss SOFA	31,570	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 690,682	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 16,716,005	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,091,678	31
32	Health Care	7,697,405	32
33	General Administration	3,882,297	33
	B. Capital Expense		
34	Ownership	436,536	34
	C. Ancillary Expense		
35	Special Cost Centers	1,573,842	35
36	Provider Participation Fee	453,713	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 16,135,471	40
41	**Income before Income Taxes (line 30 minus line 40)****	580,534	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 580,534	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,332,751	44
45	Private Pay - Net Inpatient Revenue	3,103,121	45
46	Medicare - Net Inpatient Revenue	3,635,775	46
47	Other-(specify) Insurance	830,726	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 10,902,373	49

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

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

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

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

Facility Name & ID Number Presence St Anne Center # 0041737 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	1,824	2,020	$ 95,595	$ 47.32	1
2	Assistant Director of Nursing	1,764	2,080	67,090	32.25	2
3	Registered Nurses	54,893	58,164	1,736,611	29.86	3
4	Licensed Practical Nurses	43,678	47,232	1,293,809	27.39	4
5	CNAs & Orderlies	113,727	120,438	1,504,954	12.50	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	10,147	10,869	151,804	13.97	8
9	Activity Director	1,428	1,560	26,703	17.12	9
10	Activity Assistants	8,671	9,219	108,047	11.72	10
11	Social Service Workers	5,774	6,189	112,598	18.19	11
12	Dietician	2,492	2,560	57,955	22.64	12
13	Food Service Supervisor	1,608	1,760	34,285	19.48	13
14	Head Cook					14
15	Cook Helpers/Assistants	41,406	44,110	455,130	10.32	15
16	Dishwashers					16
17	Maintenance Workers	9,410	10,243	164,836	16.09	17
18	Housekeepers	12,981	14,076	134,130	9.53	18
19	Laundry	1,085	1,101	9,189	8.35	19
20	Administrator	1,852	2,080	105,053	50.51	20
21	Assistant Administrator	1,552	1,680	53,623	31.92	21
22	Other Administrative	8,415	9,061	149,705	16.52	22
23	Office Manager	1,784	2,080	46,301	22.26	23
24	Clerical	8,089	8,970	156,243	17.42	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	5,936	6,240	196,097	31.43	32
33	Other(specify) Pastoral	2,336	2,464	53,453	21.69	33
34	TOTAL (lines 1 - 33)	340,852	364,196	$ 6,713,211 *	$ 18.43	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	120	$ 10,535	1,3	35
36	Medical Director	70	21,000	9,3	36
37	Medical Records Consultant	35	1,771	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	54	3,348	11,3	44
45	Social Service Consultant	3	189	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	282	$ 36,843		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 Presence St Anne Center # 0041737 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Janelle Chadwick	Administrator		$ 105,053
Administrative Staff	Office Manager		46,301
Administrative Staff	Human Resource		49,118
Administrative Staff	Receptionist		48,059
Administrative Staff	Admin Asst		40,065
Administrative Staff	Admissions		196,097
Betty Hilier	Asst Administrator		53,623
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 538,316

B. Administrative - Other

Description	Amount
Corp Service Fee	$ 134,400
Corp Service IS Fee	285,000
Mgmt Fee	600,804
Mgmt Fee Interest	283,596
TOTAL (agree to Schedule V, line 17, col. 3)	$ 1,303,800
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Collection Fee	Various	$ 1,356
Shredding/Storage	Various	1,006
Transportation Service	Various	8,667
Outsourced Services	Various	373
Legal	Various	16,500
Survey & Analytical Tools	Various	3,883
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 31,785

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 170,155
Unemployment Compensation Insurance	30,312
FICA Taxes	478,033
Employee Health Insurance	642,614
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Life Insurance	20,474
Pension	211,104
Employee Recognition	574
Executive Benefots	7,891
Employee Screening	33,080
Home Office Allocation	308,758
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,902,995

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

Description	Line #	Amount
N/A		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 38)	
Patient Background Checks 686	
Employee Recruitment	377
Dues & Subscription	17,215
Advertiosing & Public Relations	19,654
Home Office Allocation	10,434
Less: Public Relations Expense	( )
Non-allowable advertising	(18,477)
Yellow page advertising	(752)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 28,451

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	7,079
Seminar Expense	
Home Office Allocation	7,029
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 14,108

**See instructions.

Facility Name & ID Number Presence St Anne Center # 0041737 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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 Presence St Anne Center # 0041737 **Report Period Beginning:** 01/01/2012 **Ending:** 12/31/2012

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 $10,377**

(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. $ **66,589** 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.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **453,713**
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. $ **2,410**

(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 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.