



Facility Name & ID Number PROVENA COR MARIAE CENTER# 0041046 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

## III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,  
(must agree with license). Date of change in licensed beds \_\_\_\_\_

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>63</u>	Skilled (SNF)	<u>63</u>	<u>23,058</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	<u>89</u>	Sheltered Care (SC)	<u>89</u>	<u>32,574</u>	5
6		ICF/DD 16 or Less			6
7	<u>152</u>	TOTALS	<u>152</u>	<u>55,632</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		3 Public Aid Recipient	4 Private Pay	Other		
8	SNF	<u>4,274</u>	<u>10,377</u>	<u>6,869</u>	<u>21,520</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC		<u>29,745</u>		<u>29,745</u>	12
13	DD 16 OR LESS					13
14	TOTALS	<u>4,274</u>	<u>40,122</u>	<u>6,869</u>	<u>51,265</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed  
bed days on line 7, column 4.) 92.15%D. How many bed-hold days during this year were paid by Public Aid?  
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 - NoneF. Does the facility maintain a daily midnight census? YesG. Do pages 3 & 4 include expenses for services or  
investments not directly related to patient care?  
YES  NO H. Does the BALANCE SHEET (page 17) reflect any non-care assets?  
YES  NO I. On what date did you start providing long term care at this location?  
Date started 6/5/1995J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 6/5/1995 NO K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number  
of beds certified 41 and days of care provided 6,869Medicare Intermediary Administar Federal

## IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\* Is your fiscal year identical to your tax year? YES  NO Tax Year: 12/31/04 Fiscal Year: 12/31/04

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

## STATE OF ILLINOIS

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Facility Name & ID Number **PROVENA COR MARIAE CENTER** # **0041046** Report Period Beginning: **01/01/2004** Ending: **12/31/2004****V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	365,490	40,669	12,186	418,345		418,345		418,345		1
2	Food Purchase		310,834		310,834		310,834	2,468	313,302		2
3	Housekeeping	122,489	42,573		165,062		165,062		165,062		3
4	Laundry	55,378	10,960		66,338		66,338		66,338		4
5	Heat and Other Utilities			265,008	265,008		265,008	1,252	266,260		5
6	Maintenance	116,569	12,114	92,735	221,418		221,418	34,949	256,367		6
7	Other (specify):* <b>PastoralCare/Develop</b>	27,583	1,458	19,904	48,945		48,945	(11,220)	37,725		7
8	<b>TOTAL General Services</b>	687,509	418,608	389,833	1,495,950		1,495,950	27,449	1,523,399		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			13,800	13,800		13,800		13,800		9
10	Nursing and Medical Records	1,684,217	102,608	63,699	1,850,524		1,850,524		1,850,524		10
10a	Therapy			322,936	322,936		322,936		322,936		10a
11	Activities	230,374	11,193	7,402	248,969		248,969	2,198	251,167		11
12	Social Services	59,473	310	2,248	62,031		62,031		62,031		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,974,064	114,111	410,085	2,498,260		2,498,260	2,198	2,500,458		16
	<b>C. General Administration</b>										
17	Administrative	248,047	10,257	698,553	956,857		956,857	(383,426)	573,431		17
18	Directors Fees										18
19	Professional Services			44,340	44,340		44,340	250,891	295,231		19
20	Dues, Fees, Subscriptions & Promotions			55,194	55,194		55,194	(12,983)	42,211		20
21	Clerical & General Office Expenses		28,806	40,503	69,309		69,309	(4,794)	64,515		21
22	Employee Benefits & Payroll Taxes			664,431	664,431		664,431	101,978	766,409		22
23	Inservice Training & Education			9,208	9,208		9,208	8,264	17,472		23
24	Travel and Seminar			15,240	15,240		15,240	7,278	22,518		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			62,174	62,174		62,174	8,133	70,307		26
27	Other (specify):* <b>Bad Debt</b>			115,200	115,200		115,200	(54,906)	60,294		27
28	<b>TOTAL General Administration</b>	248,047	39,063	1,704,843	1,991,953		1,991,953	(79,565)	1,912,388		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,909,620	571,782	2,504,761	5,986,163		5,986,163	(49,918)	5,936,245		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 &amp; ID Number

PROVENA COR MARIAE CENTER

#0041046

Report Period Beginning:

01/01/2004

Ending:

12/31/2004

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			291,940	291,940		291,940	84,374	376,314			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							190,129	190,129			32
33	Real Estate Taxes			1,200	1,200		1,200		1,200			33
34	Rent-Facility & Grounds							16,027	16,027			34
35	Rent-Equipment & Vehicles			73,750	73,750		73,750	1,624	75,374			35
36	Other (specify):* <b>Loss on Asset Disposals</b>			1,615	1,615		1,615		1,615			36
37	<b>TOTAL Ownership</b>			368,505	368,505		368,505	292,154	660,659			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			248,240	248,240		248,240	1,000	249,240			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			34,587	34,587		34,587		34,587			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			282,827	282,827		282,827	1,000	283,827			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,909,620	571,782	3,156,093	6,637,495		6,637,495	243,236	6,880,731			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 COR MARIAE CENTER**

# **0041046**

Report Period Beginning: **01/01/2004**

Ending: **12/31/2004**

**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.)

		1	2	3	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>OHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				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	7,517	30		9
10	Interest and Other Investment Income	(7,820)	32		10
11	Discounts, Allowances, Rebates & Refunds	(15,831)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				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	(115,200)	27		24
25	Fund Raising, Advertising and Promotional	(33,591)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (164,925)		\$	30

<b>OHF USE ONLY</b>					
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	2	
		<b>Amount</b>	<b>Reference</b>	
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)	420,110		34
35	Other- Attach Schedule	(11,949)		35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 408,161		36
37	<b>TOTAL ADJUSTMENTS (A) and (B) (sum of SUBTOTALS)</b>	\$ 243,236		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	2	3	4	
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>	
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	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

PROVENA COR MARIAE CENTER

ID# 0041046

Report Period Beginning: 01/01/2004

Ending: 12/31/2004

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Development Salares	\$ (9,232)	7	1
2	Development Activities/Fundraising	(1,000)	7	2
3	Development Miscellaneous	(988)	7	3
4	Development Benefits	(729)	22	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	<b>Total</b>	(11,949)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number PROVENA COR MARIAE CENTER# 0041046 Report Period Beginning:01/01/2004

Ending:

12/31/2004**SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I**

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	2,468	0	0	0	0	0	0	0	0	0	2,468	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	1,252	0	0	0	0	0	0	0	0	0	1,252	5
6	Maintenance	0	447	34,502	0	0	0	0	0	0	0	0	34,949	6
7	Other (specify):*	(11,220)	0	0	0	0	0	0	0	0	0	0	(11,220)	7
8	<b>TOTAL General Services</b>	<b>(11,220)</b>	<b>4,167</b>	<b>34,502</b>	<b>0</b>	<b>27,449</b>	<b>8</b>							
	<b>B. Health Care and Programs</b>													
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	2,198	0	0	0	0	0	0	0	0	0	2,198	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide 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	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>2,198</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>2,198</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	(352,387)	(31,039)	0	0	0	0	0	0	0	0	(383,426)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	33,536	217,355	0	0	0	0	0	0	0	0	250,891	19
20	Fees, Subscriptions & Promotions	(33,591)	20,608	0	0	0	0	0	0	0	0	0	(12,983)	20
21	Clerical & General Office Expenses	(15,831)	11,037	0	0	0	0	0	0	0	0	0	(4,794)	21
22	Employee Benefits & Payroll Taxes	(729)	53,388	49,319	0	0	0	0	0	0	0	0	101,978	22
23	Inservice Training & Education	0	8,264	0	0	0	0	0	0	0	0	0	8,264	23
24	Travel and Seminar	0	7,278	0	0	0	0	0	0	0	0	0	7,278	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	8,133	0	0	0	0	0	0	0	0	0	8,133	26
27	Other (specify):*	(115,200)	0	60,294	0	0	0	0	0	0	0	0	(54,906)	27
28	<b>TOTAL General Administration</b>	<b>(165,351)</b>	<b>(210,143)</b>	<b>295,929</b>	<b>0</b>	<b>(79,565)</b>	<b>28</b>							
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(176,571)</b>	<b>(203,778)</b>	<b>330,431</b>	<b>0</b>	<b>(49,918)</b>	<b>29</b>							



**VII. RELATED PARTIES**

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

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

**B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.**  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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	2 Food	\$	Provena Senior Services	100.00%	\$ 2,468	\$ 2,468 1
2	V	5 Utilities		Provena Senior Services	100.00%	1,252	1,252 2
3	V	6 Maintenance - Other		Provena Senior Services	100.00%	447	447 3
4	V	11 Activities-Special Events		Provena Senior Services	100.00%	2,198	2,198 4
5	V	17 Admin - Misc. Other	531,537	Provena Senior Services	100.00%	5,224	(526,313) 5
6	V	17 Administrative Salaries		Provena Senior Services	100.00%	173,926	173,926 6
7	V	19 Professional Services		Provena Senior Services	100.00%	33,536	33,536 7
8	V	20 Dues,Subscriptions		Provena Senior Services	100.00%	20,608	20,608 8
9	V	21 Clerical Supplies		Provena Senior Services	100.00%	11,037	11,037 9
10	V	22 Employee Benefits		Provena Senior Services	100.00%	53,388	53,388 10
11	V	23 Education/Conference		Provena Senior Services	100.00%	8,264	8,264 11
12	V	24 Travel		Provena Senior Services	100.00%	7,278	7,278 12
13	V	26 Insurance		Provena Senior Services	100.00%	8,133	8,133 13
14	Total		\$ 531,537			\$ 327,759	\$ * (203,778) 14

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

Facility Name & ID Number PROVENA COR MARIAE CENTER

# 0041046

Report Period Beginning: 01/01/2004 Ending: 12/31/2004

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.  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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	27	Bad Debt	\$	Provena Senior Services	100.00%	\$ 60,294	\$ 60,294	15
16	V	30	Depreciation		Provena Senior Services	100.00%	3,284	3,284	16
17	V	32	Interest		Provena Senior Services	100.00%	197,949	197,949	17
18	V	34	Rent - Facility		Provena Senior Services	100.00%	16,027	16,027	18
19	V	35	Rent - Equipment		Provena Senior Services	100.00%	1,624	1,624	19
20	V	17	Admin Salaries	97,572	Provena Health Services	100.00%	63,242	(34,330)	20
21	V	22	Employee Benefits		Provena Health Services	100.00%	22,911	22,911	21
22	V	30	Depreciation		Provena Health Services	100.00%	73,573	73,573	22
23	V	19	Admin Consulting,Other		Provena Health Services	100.00%	217,355	217,355	23
24	V	17	Information Systems Salaries	69,444	Provena Health Services	100.00%	13,336	(56,108)	24
25	V	22	Information Systems Benefits		Provena Health Services	100.00%	4,889	4,889	25
26	V	6	Information Systems - Equip Maint		Provena Health Services	100.00%	6,530	6,530	26
27	V	17	Admin Salaries		Provena Health Services	100.00%	38,327	38,327	27
28	V	22	Employee Benefits		Provena Health Services	100.00%	13,885	13,885	28
29	V	17	Information Systems Salaries		Provena Health Services	100.00%	21,072	21,072	29
30	V	22	Information Systems Benefits		Provena Health Services	100.00%	7,634	7,634	30
31	V	6	Information Systems - Equip Maint		Provena Health Services	100.00%	27,972	27,972	31
32	V	39	Ancillary Services - Other	248,240	Provena Senior Services Pharmacy	100.00%	249,240	1,000	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 415,256			\$ 1,039,144	\$ * 623,888		39

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

Facility Name & ID Number      **PROVENA COR MARIAE CENTER**      #      **0041046**      Report Period Beginning:      **01/01/2004**      Ending:      **12/31/2004**

## 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								<b>TOTAL</b>	\$	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 COR MARIAE CENTER # 0041046 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES  NO

Name of Related Organization Provena Senior Services  
 Street Address 19065 Hickory Creek Drive, Ste 310  
 City / State / Zip Code Mokena, IL60448  
 Phone Number (708)478-7900  
 Fax Number (708)478-5387

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

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	4,942,944	16	\$ 22,950	\$ 531,537	\$ 2,468	1
2	5	Utilities	Management Fee Income	4,942,944	16	11,646	531,537	1,252	2
3	6	Maintenance - Other	Management Fee Income	4,942,944	16	4,154	531,537	447	3
4	11	Activities-Special Events	Management Fee Income	4,942,944	16	20,442	531,537	2,198	4
5	17	Admin - Misc. Other	Management Fee Income	4,942,944	16	48,582	531,537	5,224	5
6	17	Administrative Salaries	Management Fee Income	4,942,944	16	1,617,398	1,617,398	173,926	6
7	19	Professional Services	Management Fee Income	4,942,944	16	311,867	531,537	33,536	7
8	20	Dues,Subscriptions	Management Fee Income	4,942,944	16	191,638	531,537	20,608	8
9	21	Clerical Supplies	Management Fee Income	4,942,944	16	102,640	531,537	11,037	9
10	22	Employee Benefits	Management Fee Income	4,942,944	16	496,473	531,537	53,388	10
11	23	Education/Conference	Management Fee Income	4,942,944	16	76,847	531,537	8,264	11
12	24	Travel	Management Fee Income	4,942,944	16	67,676	531,537	7,278	12
13	26	Insurance	Management Fee Income	4,942,944	16	75,628	531,537	8,133	13
14	27	Bad Debt	Management Fee Income	4,942,944	16	560,691	531,537	60,294	14
15	30	Depreciation	Management Fee Income	4,942,944	16	30,542	531,537	3,284	15
16	32	Interest	Management Fee Income	4,942,944	16	1,840,794	531,537	197,949	16
17	34	Rent - Facility	Management Fee Income	4,942,944	16	149,043	531,537	16,027	17
18	35	Rent - Equipment	Management Fee Income	4,942,944	16	15,101	531,537	1,624	18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 5,644,112	\$ 1,617,398	\$ 606,937	25

Facility Name & ID Number PROVENA COR MARIAE CENTER # 0041046 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES  NO

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

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

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	1,101,876		\$ 714,188	\$ 714,188	97,572	\$ 63,242	1
2	22 Employee Benefits	Operating Expense	1,101,876		258,738		97,572	22,911	2
3	30 Depreciation	Operating Expense	1,101,876		830,857		97,572	73,573	3
4	19 Admin Consulting,Other	Operating Expense	1,101,876		2,454,578		97,572	217,355	4
5	17 Information Systems Salaries	Operating Expense	761,172		146,180	146,180	69,444	13,336	5
6	22 Information Systems Benefits	Operating Expense	761,172		53,593		69,444	4,889	6
7	6 Information Systems - Equip Maint	Operating Expense	761,172		71,577		69,444	6,530	7
8	17 Admin Salaries	Direct Cost	1,101,876		432,829	432,829	97,572	38,327	8
9	22 Employee Benefits	Direct Cost	1,101,876		156,806		97,572	13,885	9
10	17 Information Systems Salaries	Direct Cost	761,172		230,974	230,974	69,444	21,072	10
11	22 Information Systems Benefits	Direct Cost	761,172		83,678		69,444	7,634	11
12	6 Information Systems - Equip Maint	Direct Cost	761,172		306,605		69,444	27,972	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				\$ 5,740,603	\$ 1,524,171		\$ 510,726	25

Facility Name & ID Number PROVENA COR MARIAE CENTER # 0041046 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES  NO

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

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

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 Cost		\$	\$		\$ 249,240	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				\$	\$		\$ 249,240	25

**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						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
	<b>A. Directly Facility Related</b>																	
	<b>Long-Term</b>																	
1							\$	\$			\$	1						
2												2						
3												3						
4												4						
5												5						
	<b>Working Capital</b>																	
6												6						
7												7						
8												8						
9	<b>TOTAL Facility Related</b>						\$	\$			\$	9						
	<b>B. Non-Facility Related*</b>																	
10	<b>Provena Senior Services</b>											<b>190,129</b>	10					
11													11					
12													12					
13													13					
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	<b>190,129</b>	14					
15	<b>TOTALS (line 9+line14)</b>						\$	\$			\$	<b>190,129</b>	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 COR MARIAE CENTER**# **0041046** Report Period Beginning: **01/01/2004** Ending: **12/31/2004****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

		<b>Important</b> , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1.	Real Estate Tax accrual used on 2003 report.		\$	1,884	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.)		\$	974	2
3.	Under or (over) accrual (line 2 minus line 1).		\$	(910)	3
4.	Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	2,110	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		6
7.	Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	1,200	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		1999	_____	8	
		2000	_____	9	
		2001	942	10	
		2002	_____	11	
		2003	974	12	
<b>FOR OHF USE ONLY</b>					
		13	FROM R. E. TAX STATEMENT FOR 2003	\$	13
		14	PLUS APPEAL COST FROM LINE 5	\$	14
		15	LESS REFUND FROM LINE 6	\$	15
		16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

**NOTES:**

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Office of Health Finance at (217) 782-1630.

**2003 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME PROVENA COR MARIAE CENTER COUNTY WINNEBAGO

FACILITY IDPH LICENSE NUMBER 0041046

CONTACT PERSON REGARDING THIS REPORT Lynda Olinski

TELEPHONE 708-478-7916 FAX #: 708-478-5387

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

Enter the tax index number and real estate tax assessed for 2003 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 2003.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>153B004C 12-09-104-035</u>	<u>COMM SE COR LT IMPERIAL</u>	\$ <u>973.66</u>	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>973.66</u>	\$ <u>_____</u>

**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 & 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 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

A. Square Feet: 110,404 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 5

C. Does the Operating Entity?  (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?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).  
None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?  YES  NO  
 If so, please complete the following:

1. Total Amount Incurred: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_  
 3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

Nature of Costs: \_\_\_\_\_  
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Nursing Home		1995	\$ 670,894	1
2					2
3	TOTALS			\$ 670,894	3

Facility Name & ID Number PROVENA COR MARIAE CENTER# 0041046

Report Period Beginning:

01/01/2004 Ending: 12/31/2004**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	89	1995	1964	\$ 1,035,000	\$ 36,833	20	\$ 36,833	\$	\$ 349,917
5	63		1997	2,508,246	62,711	40	62,711		454,460
6									
7									
8									
<b>Improvement Type**</b>									
9	VARIOUS		1995	174,095	8,757	20	8,757		78,534
10	VARIOUS		1996	374,066	21,294	15	21,294		167,304
11	VARIOUS		1997	253,146	5,040	13	5,040		134,027
12	VARIOUS		1998	175,915	5,239	11	5,239		52,795
13	VARIOUS		1999	10,976	1,098	6	1,098		10,775
14	VARIOUS		2000	47,412	8,306	6	8,306		37,379
15									
16	DESC: RGB ARCHITECTURAL SERVICES		2001	225	45	5	45		158
17	DESC: 1ST FLOOR REMODELING		2001	16,085	804	20	804		2,815
18	DESC: RGB ARCHITECTURAL SERVICES (4/27)		2001	225	45	5	45		158
19	DESC: PENTHOUSE RENOVATIONS		2001	2,264	453	5	453		1,584
20	DESC: ROOFING REPAIRS		2001	1,115	223	5	223		781
21	DESC: 2ND FLOOR REMODELING		2001	612	31	20	31		107
22	DESC: REFRIGERANT		2001	4,400	880	5	880		3,080
23	DESC: ELEVATOR #2 PENTHOUSE ROOF REPAIRS		2001	21,328	2,133	10	2,133		7,465
24	DESC: REMODEL NURSE'S STATION - 1ST FLOOR		2001	4,125	413	10	413		1,444
25	DESC: ROOFING REPAIRS - CHAPEL		2001	300	60	5	60		210
26									
27	DESC: METROFAX SHELVES & POSTS		2002			20			41
28	DESC: ARCHITECT SITE VISIT		2002	2,104	301	7	301		751
29	DESC: KITCHEN AREA WALLS		2002	2,475	495	5	495		1,238
30	DESC: AUTOMATIC OPERATOR ASSEMBLY FOR ENTR		2002	6,820	682	10	682		1,364
31	DESC: AUTOMATIC OPERATOR ASSEMBLY FOR ENTR		2002	1,680	168	10	168		336
32	DESC: 3RD FLOOR REMODLING		2002	59,484	3,966	15	3,966		8,879
33	DESC: FREEZER REPAIR-PARTS		2002	1,203	241	5	241		601
34	DESC: ROOFING		2002	27,000	2,700	10	2,700		6,750
35	DESC: ROOFING		2002	15,300	1,530	10	1,530		3,825
36			2002	1,953	391	5	391		977

\*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 &amp; ID Number PROVENA COR MARIAE CENTER

# 0041046

Report Period Beginning:

01/01/2004 Ending: 12/31/2004

## XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	DESC: INSTALLATION OF AWNING	2003	\$ 1,710	\$ 171	10	\$ 171	\$	\$ 257	37
38	DESC: JOCKEY PUMP AND CONTROLLER	2003	3,340	167	20	167		251	38
39	DESC: REROOFING	2003	5,325	533	10	533		799	39
40	DESC: REPAIR SHOWER FLOOR	2003	744	74	10	74		112	40
41	DESC: REPLACE BOILER SHEET METAL STACK	2003	2,560	128	20	128		192	41
42	DESC: COMPRESSOR FOR FREEZER	2003	584	58	10	58		88	42
43	DESC: COUNTER TOPS FOR THERAPY KITCHEN ARE	2003	1,103	110	10	110		166	43
44	DESC: ALARM SYSTEM	2003	11,753	1,175	10	1,175		1,763	44
45	DESC: DOOR OPERATOR FOR MAIN ENTRANCE	2003	2,157	216	10	216		216	45
46	DESC: FREEZER REPAIR	2003	1,726	345	5	345		518	46
47	DESC: CODE ALERT SYSTEM	2003	4,700	470	10	470		705	47
48	DESC: CARPET INSTALLATION	2003	1,937	387	5	387		581	48
49	DESC: CARPET INSTALLATION	2003	90,500	18,100	5	18,100		18,100	49
50									50
51	DESC: REPAIR OUTSIDE LIGHTS	2004	2,369	158	15	158		158	51
52	DESC: ROOF REPLACEMENT	2004	38,000	3,800	10	3,800		3,800	52
53	DESC: TOSHIBA CTX670 TELEPHONE SYSTEM	2004	33,116	1,656	10	3,312	1,656	3,312	53
54	DESC: REPAIR WATERMAIN	2004	2,712	90	15	181	90	181	54
55	DESC: FRENCH DOORS	2004	4,000	133	15	267	133	267	55
56	DESC: PLAN BIDDING AND NEGOTIATION	2004	3,187	319	5	637	319	637	56
57	DESC: WATER MAIN REPAIR	2004	6,819	227	15	455	227	455	57
58	DESC: EXTRACTION OF WATER - WATER DAMAGE	2004	1,040	104	5	208	104	208	58
59	DESC: CALL LIGHT ITMING SYSTEM FOR SKILLED	2004	4,208	210	10	421	210	421	59
60	DESC: SEAL & STRIPING OF PARKING LOTS	2004	7,008	701	5	1,402	701	1,402	60
61	DESC: DRAFTING OF DESIGN DRAWINGS - SNF AD	2004	610	61	5	122	61	122	61
62	DESC: SAW AND PATCH	2004	2,494	249	5	499	249	499	62
63	DESC: UPGRADE KIT FOR SURFACE CODE ALERT U	2004	733	73	5	147	73	147	63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 4,981,986	\$ 194,553		\$ 198,378	\$ 3,824	\$ 1,363,103	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,107,831	\$ 88,502	\$ 88,502	\$	8	\$ 587,202	71
72	Current Year Purchases	103,024	4,634	9,268	4,634		9,268	72
73	Fully Depreciated Assets	90,885					90,885	73
74	Home Office Allocation			76,857	76,857			74
75	TOTALS	\$ 1,301,741	\$ 93,136	\$ 174,627	\$ 81,491		\$ 687,356	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Plant Engineering	1991 CHEVY PICKUP	1995	\$ 14,000	\$	\$	\$	5	\$ 14,000	76
77	Plant Engineering	2000 FORD ELDORADO	2000	42,500	4,250	4,250		10	19,125	77
78		NONCARE PORTION	2001	(15,062)		(941)	(941)		(9,883)	78
79										79
80	TOTALS			\$ 41,438	\$ 4,250	\$ 3,309	\$ (941)		\$ 23,242	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)	\$ 6,996,059	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 291,940	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 376,314	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 84,374	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,073,700	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.

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: N/A  
 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				16,027			5
6								6
7	<b>TOTAL</b>				\$ 16,027			7

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.	<u>/2005</u>	\$ _____
13.	<u>/2006</u>	\$ _____
14.	<u>/2007</u>	\$ _____

8. List separately any amortization of lease expense included on page 4, line 34.  
 This amount was calculated by dividing the total amount to be amortized \_\_\_\_\_  
 by the length of the lease \_\_\_\_\_.

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

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

15. Is Movable equipment rental included in building rental?  YES  NO  
 16. Rental Amount for movable equipment: \$ 75,374 Description: Nursing - \$71,756.38, Activities - \$7.80, Plant Eng - \$588.34, Administration - \$570.34, Home Office - \$1,624  
 (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	<b>TOTAL</b>		\$	\$	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.

**XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)**

**A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)**

<p><b>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</b></p> <p><input type="checkbox"/> YES      <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p><b>2. CLASSROOM PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p><b>3. CLINICAL PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
--	--	---

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility			
		1	2	3	4
		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	Nurse Aide Competency Tests				
9	<b>TOTALS</b>	\$	\$	\$	\$
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 aides from other facilities.

\$

**D. NUMBER OF AIDES TRAINED**

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

- (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 aide 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 aides.
- (e) The total amount of Drop-out and Completed Costs for your own aides 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 aides.

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Staff		Outside Practitioner (other than consultant)		Units	Cost	Units	Cost				
			Units of Service	Cost	Units	Cost								
1	Licensed Occupational Therapist	10a, 3	hrs	\$	2,755	\$	143,821	\$	2,755	\$	143,821	1		
2	Licensed Speech and Language Development Therapist	10a,3	hrs		246		12,845		246		12,845	2		
3	Licensed Recreational Therapist		hrs									3		
4	Licensed Physical Therapist	10a,3	hrs		3,185		166,269		3,185		166,269	4		
5	Physician Care		visits									5		
6	Dental Care		visits									6		
7	Work Related Program		hrs									7		
8	Habilitation		hrs									8		
9	Pharmacy		# of prescripts						248,240		248,240	9		
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10		
11	Academic Education		hrs									11		
12	Exceptional Care Program											12		
13	Other (specify):											13		
14	<b>TOTAL</b>			\$	6,186	\$	322,936	\$	248,240	\$	6,186	\$	571,175	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 nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number **PROVENA COR MARIAE CENTER**

# **0041046**

Report Period Beginning: **01/01/2004**

Ending:

**12/31/2004**

**XV. BALANCE SHEET - Unrestricted Operating Fund.**

As of **12/31/2004**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 8,885,741	\$	1
2	Cash-Patient Deposits	102,693		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	8,420,236		3
4	Supply Inventory (priced at )	588,898		4
5	Short-Term Investments			5
6	Prepaid Insurance	7,152		6
7	Other Prepaid Expenses	124,516		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 18,129,236	\$	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments	7,836,704		12
13	Land	6,851,272		13
14	Buildings, at Historical Cost	74,980,161		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	13,506,539		16
17	Accumulated Depreciation (book methods)	(40,776,212)		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): <b>Goodwill</b>	140,712		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 62,539,176	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 80,668,412	\$	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 1,746,542	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,611,167		28
29	Short-Term Notes Payable	31,980		29
30	Accrued Salaries Payable	1,849,317		30
31	Accrued Taxes Payable (excluding real estate taxes)	44,053		31
32	Accrued Real Estate Taxes(Sch.IX-B)	240,643		32
33	Accrued Interest Payable	23,513		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<b>Due to Related Party</b>	988,855		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 6,536,070	\$	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable	1,363,410		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	143,623		42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 1,507,033	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 8,043,103	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 72,625,309	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 80,668,412	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>31,464,506</b>	1
2	Restatements (describe):		2
3			3
4	<b>Adj. To Reconcile Consolidated Equity and Consolidated</b>		4
5	<b>Net Income to Nursing Facility Amounts</b>	<b>315,762</b>	5
6	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>31,780,268</b>	6
	<b>A. Additions (deductions):</b>		
7	NET Income (Loss) (from page 19, line 43)	<b>238,715</b>	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>238,715</b>	17
	<b>B. Transfers (Itemize):</b>		
18	<b>Transfer Debt to Provena Health</b>	<b>40,606,326</b>	18
19			19
20			20
21			21
22			22
23	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$ <b>40,606,326</b>	23
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>72,625,309</b>	24 *

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

Facility Name &amp; ID Number PROVENA COR MARIAE CENTER

# 0041046

Report Period Beginning: 01/01/2004

Ending: 12/31/2004

**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.**

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 5,866,416	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 5,866,416	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	640,172	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 640,172	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	322,165	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	2,862	20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 325,027	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	20,944	24
25	Interest and Other Investment Income***	7,820	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 28,764	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Purchase Rebates</u>	15,831	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 15,831	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 6,876,210	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,495,950	31
32	Health Care	2,498,260	32
33	General Administration	1,991,953	33
<b>B. Capital Expense</b>			
34	Ownership	368,505	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	248,240	35
36	Provider Participation Fee	34,587	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 6,637,495	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	238,715	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 238,715	43

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

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

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

Facility Name & ID Number **PROVENA COR MARIAE CENTER**

# **0041046**

Report Period Beginning: **01/01/2004**

Ending:

**12/31/2004**

**XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)**

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,032	2,160	\$ 82,887	\$ 38.37	1
2	Assistant Director of Nursing	1,648	1,740	55,963	32.16	2
3	Registered Nurses	8,696	9,676	255,860	26.44	3
4	Licensed Practical Nurses	21,412	23,640	461,687	19.53	4
5	Nurse Aides & Orderlies	63,655	69,057	761,292	11.02	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,536	4,927	66,528	13.50	8
9	Activity Director	3,690	4,047	59,259	14.64	9
10	Activity Assistants	18,295	19,382	171,115	8.83	10
11	Social Service Workers	3,915	4,255	59,473	13.98	11
12	Dietician	1,904	2,160	44,146	20.44	12
13	Food Service Supervisor	3,449	3,691	40,609	11.00	13
14	Head Cook	7,800	8,352	89,835	10.76	14
15	Cook Helpers/Assistants	25,595	27,069	190,900	7.05	15
16	Dishwashers					16
17	Maintenance Workers	7,499	8,193	116,569	14.23	17
18	Housekeepers	14,476	15,909	122,489	7.70	18
19	Laundry	6,436	6,958	55,378	7.96	19
20	Administrator	1,920	2,160	104,023	48.16	20
21	Assistant Administrator					21
22	Other Administrative	5,942	6,358	78,557	12.36	22
23	Office Manager					23
24	Clerical	6,658	7,142	65,467	9.17	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>Pastoral/Develop</u>	2,481	2,664	27,583	10.35	33
34	TOTAL (lines 1 - 33)	212,039	229,540	\$ 2,909,620 *	\$ 12.68	34

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

\*\* See instructions.

**B. CONSULTANT SERVICES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	209	\$ 10,661	1,3	35
36	Medical Director	\$1150/mth	13,800	9,3	36
37	Medical Records Consultant	23	1,326	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				44
45	Social Service Consultant	38	2,248	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	270	\$ 28,035		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	65	\$ 2,508	10,3	50
51	Licensed Practical Nurses	156	5,047	10,3	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	221	\$ 7,555		53





Facility Name & ID Number **PROVENA COR MARIAE CENTER**# **0041046**Report Period Beginning: **01/01/2004** Ending: **12/31/2004****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. 6514-Life Services Network
- (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? Yes If YES, what is the capacity? 152
- (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. \$ 10,247 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 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 of Public Aid during this cost report period. \$ 34,587  
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 of Public Aid, 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? No Indicate the amount. \$ None
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? N/A
- d. Have vehicle usage logs been maintained? N/A
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: KPMG The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Not issued yet
- (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 \$2500, 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.