

		FOR OHF USE				

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

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.

<p>I. IDPH Facility ID Number: <u>0041871</u></p> <p>Facility Name: <u>PROVENA ST. JOSEPH CENTER</u></p> <p>Address: <u>659 E. JEFFERSON</u> <u>FREEPORT</u> <u>61032</u> Number City Zip Code</p> <p>County: <u>STEPHENSON</u></p> <p>Telephone Number: <u>(815) 232-6181</u> Fax # <u>(815) 232-6143</u></p> <p>IDPA ID Number: <u>371127787011</u></p> <p>Date of Initial License for Current Owners: <u>07/01/96</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input checked="" type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code <u>501 (C3)</u></td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Lynda Olinski</u> Telephone Number: <u>(708) 478-7916</u></p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code <u>501 (C3)</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/04</u> to <u>12/31/04</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td data-bbox="1144 673 1281 828">Officer or Administrator of Provider</td> <td data-bbox="1281 673 1921 747">(Signed) _____ (Date) _____ (Type or Print Name) <u>Michael R. Gordon</u></td> </tr> <tr> <td data-bbox="1144 828 1281 1039">Paid Preparer</td> <td data-bbox="1281 828 1921 1039">(Title) <u>VP of Finance, CFO</u> (Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) (____) _____ Fax # (____) _____</td> </tr> </table> <p align="center">MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Date) _____ (Type or Print Name) <u>Michael R. Gordon</u>	Paid Preparer	(Title) <u>VP of Finance, CFO</u> (Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) (____) _____ Fax # (____) _____
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																											
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<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County																											
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Officer or Administrator of Provider	(Signed) _____ (Date) _____ (Type or Print Name) <u>Michael R. Gordon</u>																												
Paid Preparer	(Title) <u>VP of Finance, CFO</u> (Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) (____) _____ Fax # (____) _____																												

Facility Name & ID Number PROVENA ST. JOSEPH CENTER

0041871 Report Period Beginning: 01/01/04 Ending: 12/31/04

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	120	Skilled (SNF)	120	43,920	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	120	TOTALS	120	43,920	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other		Total
8	SNF	18,529	19,782	3,182	41,493	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,529	19,782	3,182	41,493	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.47%

D. How many bed-hold days during this year were paid by Public Aid? 42 (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

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 7/1/1996

J. Was the facility purchased or leased after January 1, 1978?
YES Date 7/1/1996 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 16 and days of care provided 3,182

Medicare 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.

Facility Name & ID Number **PROVENA ST. JOSEPH CENTER** # **0041871** Report Period Beginning: **01/01/04** Ending: **12/31/04**

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
	A. General Services										
1	Dietary	285,214	15,275	11,927	312,416		312,416		312,416		1
2	Food Purchase		185,796		185,796		185,796	(39,230)	146,566		2
3	Housekeeping	81,167	42,384	31	123,582		123,582		123,582		3
4	Laundry	105,114	9,399		114,513		114,513		114,513		4
5	Heat and Other Utilities			296,571	296,571		296,571	1,141	297,712		5
6	Maintenance	87,165	11,121	69,058	167,344		167,344	28,464	195,808		6
7	Other (specify):* Pastoral Care/Develop	33,236	267	14,276	47,779		47,779	(23,890)	23,889		7
8	TOTAL General Services	591,896	264,242	391,863	1,248,001		1,248,001	(33,515)	1,214,486		8
	B. Health Care and Programs										
9	Medical Director			12,075	12,075		12,075		12,075		9
10	Nursing and Medical Records	1,748,501	107,280	129,609	1,985,390		1,985,390		1,985,390		10
10a	Therapy			121,945	121,945		121,945		121,945		10a
11	Activities	63,017	791	2,944	66,752		66,752	2,003	68,755		11
12	Social Services	55,790		1,092	56,882		56,882		56,882		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,867,308	108,071	267,665	2,243,044		2,243,044	2,003	2,245,047		16
	C. General Administration										
17	Administrative	166,631	2,867	622,485	791,983		791,983	(346,183)	445,800		17
18	Directors Fees										18
19	Professional Services			16,149	16,149		16,149	212,676	228,825		19
20	Dues, Fees, Subscriptions & Promotions			31,691	31,691		31,691	3,247	34,938		20
21	Clerical & General Office Expenses		11,116	32,486	43,602		43,602	1,154	44,756		21
22	Employee Benefits & Payroll Taxes			628,968	628,968		628,968	88,417	717,385		22
23	Inservice Training & Education			9,065	9,065		9,065	7,529	16,594		23
24	Travel and Seminar			7,884	7,884		7,884	6,630	14,514		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			67,960	67,960		67,960	7,409	75,369		26
27	Other (specify):* Bad Debt			60,000	60,000		60,000	(5,069)	54,931		27
28	TOTAL General Administration	166,631	13,983	1,476,688	1,657,302		1,657,302	(24,190)	1,633,112		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,625,835	386,296	2,136,216	5,148,347		5,148,347	(55,702)	5,092,645		29

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

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

Facility Name & ID Number

PROVENA ST. JOSEPH CENTER

#0041871

Report Period Beginning:

01/01/04

Ending:

12/31/04

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	
	D. Ownership											
30	Depreciation			180,071	180,071		180,071	79,021	259,092			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							178,246	178,246			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds							14,602	14,602			34
35	Rent-Equipment & Vehicles			24,925	24,925		24,925	1,479	26,404			35
36	Other (specify):* Loss on Asset Disposals			5,200	5,200		5,200		5,200			36
37	TOTAL Ownership			210,196	210,196		210,196	273,348	483,544			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			114,318	114,318		114,318		114,318			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			65,880	65,880		65,880		65,880			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			180,198	180,198		180,198		180,198			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,625,835	386,296	2,526,610	5,538,741		5,538,741	217,646	5,756,387			45

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

Facility Name & ID Number **PROVENA ST. JOSEPH CENTER**

0041871

Report Period Beginning: **01/01/04**

Ending: **12/31/04**

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	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(41,478)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	14,382	30		9
10	Interest and Other Investment Income	(2,095)	32		10
11	Discounts, Allowances, Rebates & Refunds	(8,902)	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	(60,000)	27		24
25	Fund Raising, Advertising and Promotional	(15,528)	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	SUBTOTAL (A): (Sum of lines 1-29)	\$ (113,621)		\$	30

OHF 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	2	
		Amount	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)	356,396		34
35	Other- Attach Schedule	(25,129)		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 331,267		36
37	TOTAL ADJUSTMENTS (A) and (B) (sum of SUBTOTALS)	\$ 217,646		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	
		Yes	No	Amount	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	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

PROVENA ST. JOSEPH CENTER

ID# 0041871

Report Period Beginning: 01/01/04

Ending: 12/31/04

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Development Salares	\$ (13,392)	7	1
2	Development Activities/Fundraising	(218)	7	2
3	Development Miscellaneous	(10,280)	7	3
4	Development Benefits	(1,239)	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
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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	(25,129)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number **PROVENA ST. JOSEPH CENTER**# **0041871** Report Period Beginning:**01/01/04**

Ending:

12/31/04**SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I**

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(41,478)	2,248	0	0	0	0	0	0	0	0	0	(39,230)	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	1,141	0	0	0	0	0	0	0	0	0	1,141	5
6	Maintenance	0	407	28,057	0	0	0	0	0	0	0	0	28,464	6
7	Other (specify):*	(23,890)	0	0	0	0	0	0	0	0	0	0	(23,890)	7
8	TOTAL General Services	(65,368)	3,796	28,057	0	(33,515)	8							
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	2,003	0	0	0	0	0	0	0	0	0	2,003	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	TOTAL Health Care and Programs	0	2,003	0	0	0	0	0	0	0	0	0	2,003	16
	C. General Administration													
17	Administrative	0	(321,042)	(25,141)	0	0	0	0	0	0	0	0	(346,183)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	30,553	182,123	0	0	0	0	0	0	0	0	212,676	19
20	Fees, Subscriptions & Promotions	(15,528)	18,775	0	0	0	0	0	0	0	0	0	3,247	20
21	Clerical & General Office Expenses	(8,902)	10,056	0	0	0	0	0	0	0	0	0	1,154	21
22	Employee Benefits & Payroll Taxes	(1,239)	48,639	41,017	0	0	0	0	0	0	0	0	88,417	22
23	Inservice Training & Education	0	7,529	0	0	0	0	0	0	0	0	0	7,529	23
24	Travel and Seminar	0	6,630	0	0	0	0	0	0	0	0	0	6,630	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	7,409	0	0	0	0	0	0	0	0	0	7,409	26
27	Other (specify):*	(60,000)	0	54,931	0	0	0	0	0	0	0	0	(5,069)	27
28	TOTAL General Administration	(85,669)	(191,451)	252,930	0	(24,190)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(151,037)	(185,652)	280,987	0	(55,702)	29							

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%	\$ 2,248	\$ 2,248 1
2	V	5 Utilities		Provena Senior Services	100.00%	1,141	1,141 2
3	V	6 Maintenance - Other		Provena Senior Services	100.00%	407	407 3
4	V	11 Activities-Special Events		Provena Senior Services	100.00%	2,003	2,003 4
5	V	17 Admin - Misc. Other		Provena Senior Services	100.00%	4,760	4,760 5
6	V	17 Administrative Salaries	484,257	Provena Senior Services	100.00%	158,455	(325,802) 6
7	V	19 Professional Services		Provena Senior Services	100.00%	30,553	30,553 7
8	V	20 Dues,Subscriptions		Provena Senior Services	100.00%	18,775	18,775 8
9	V	21 Clerical Supplies		Provena Senior Services	100.00%	10,056	10,056 9
10	V	22 Employee Benefits		Provena Senior Services	100.00%	48,639	48,639 10
11	V	23 Education/Conference		Provena Senior Services	100.00%	7,529	7,529 11
12	V	24 Travel		Provena Senior Services	100.00%	6,630	6,630 12
13	V	26 Insurance		Provena Senior Services	100.00%	7,409	7,409 13
14	Total		\$ 484,257			\$ 298,605	\$ * (185,652) 14

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

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%	\$ 54,931	\$ 54,931	15
16	V	30	Depreciation		Provena Senior Services	100.00%	2,992	2,992	16
17	V	32	Interest		Provena Senior Services	100.00%	180,341	180,341	17
18	V	34	Rent - Facility		Provena Senior Services	100.00%	14,602	14,602	18
19	V	35	Rent - Equipment		Provena Senior Services	100.00%	1,479	1,479	19
20	V	17	Admin Salaries	81,756	Provena Health Services	100.00%	52,991	(28,765)	20
21	V	22	Employee Benefits		Provena Health Services	100.00%	19,198	19,198	21
22	V	30	Depreciation		Provena Health Services	100.00%	61,647	61,647	22
23	V	19	Admin Consulting,Other		Provena Health Services	100.00%	182,123	182,123	23
24	V	17	Information Systems Salaries		Provena Health Services	100.00%	10,845	10,845	24
25	V	22	Information Systems Benefits		Provena Health Services	100.00%	3,976	3,976	25
26	V	6	Information Systems - Equip Maint		Provena Health Services	100.00%	5,310	5,310	26
27	V	17	Admin Salaries	56,472	Provena Health Services	100.00%	32,115	(24,357)	27
28	V	22	Employee Benefits		Provena Health Services	100.00%	11,635	11,635	28
29	V	17	Information Systems Salaries		Provena Health Services	100.00%	17,136	17,136	29
30	V	22	Information Systems Benefits		Provena Health Services	100.00%	6,208	6,208	30
31	V	6	Information Systems - Equip Maint		Provena Health Services	100.00%	22,747	22,747	31
32	V	39	Ancillary Services - Other	114,318	Provena Senior Services Pharmacy	100.00%	114,318		32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 252,546			\$ 794,594	\$ * 542,048		39

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

Facility Name & ID Number **PROVENA ST. JOSEPH CENTER** # **0041871** Report Period Beginning: **01/01/04** Ending: **12/31/04**

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 PROVENA ST. JOSEPH CENTER # 0041871 Report Period Beginning: 01/01/04 Ending: 12/31/04

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	\$ 484,257	\$ 2,248	1
2	5	Utilities	Management Fee Income	4,942,944	16	11,646	484,257	1,141	2
3	6	Maintenance - Other	Management Fee Income	4,942,944	16	4,154	484,257	407	3
4	11	Activities-Special Events	Management Fee Income	4,942,944	16	20,442	484,257	2,003	4
5	17	Admin - Misc. Other	Management Fee Income	4,942,944	16	48,582	484,257	4,760	5
6	17	Administrative Salaries	Management Fee Income	4,942,944	16	1,617,398	1,617,398	158,455	6
7	19	Professional Services	Management Fee Income	4,942,944	16	311,867	484,257	30,553	7
8	20	Dues,Subscriptions	Management Fee Income	4,942,944	16	191,638	484,257	18,775	8
9	21	Clerical Supplies	Management Fee Income	4,942,944	16	102,640	484,257	10,056	9
10	22	Employee Benefits	Management Fee Income	4,942,944	16	496,473	484,257	48,639	10
11	23	Education/Conference	Management Fee Income	4,942,944	16	76,847	484,257	7,529	11
12	24	Travel	Management Fee Income	4,942,944	16	67,676	484,257	6,630	12
13	26	Insurance	Management Fee Income	4,942,944	16	75,628	484,257	7,409	13
14	27	Bad Debt	Management Fee Income	4,942,944	16	560,691	484,257	54,931	14
15	30	Depreciation	Management Fee Income	4,942,944	16	30,542	484,257	2,992	15
16	32	Interest	Management Fee Income	4,942,944	16	1,840,794	484,257	180,341	16
17	34	Rent - Facility	Management Fee Income	4,942,944	16	149,043	484,257	14,602	17
18	35	Rent - Equipment	Management Fee Income	4,942,944	16	15,101	484,257	1,479	18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 5,644,112	\$ 1,617,398	\$ 552,950	25

Facility Name & ID Number PROVENA ST. JOSEPH CENTER # 0041871 Report Period Beginning: 01/01/04 Ending: 12/31/04

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	81,756	\$ 52,991	1
2	22 Employee Benefits	Operating Expense	1,101,876		258,738		81,756	19,198	2
3	30 Depreciation	Operating Expense	1,101,876		830,857		81,756	61,647	3
4	19 Admin Consulting,Other	Operating Expense	1,101,876		2,454,578		81,756	182,123	4
5	17 Information Systems Salaries	Operating Expense	761,172		146,180	146,180	56,472	10,845	5
6	22 Information Systems Benefits	Operating Expense	761,172		53,593		56,472	3,976	6
7	6 Information Systems - Equip Maint	Operating Expense	761,172		71,577		56,472	5,310	7
8	17 Admin Salaries	Direct Cost	1,101,876		432,829	432,829	81,756	32,115	8
9	22 Employee Benefits	Direct Cost	1,101,876		156,806		81,756	11,635	9
10	17 Information Systems Salaries	Direct Cost	761,172		230,974	230,974	56,472	17,136	10
11	22 Information Systems Benefits	Direct Cost	761,172		83,678		56,472	6,208	11
12	6 Information Systems - Equip Maint	Direct Cost	761,172		306,605		56,472	22,747	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		\$ 425,931	25

Facility Name & ID Number PROVENA ST. JOSEPH CENTER # 0041871 Report Period Beginning: 01/01/04 Ending: 12/31/04

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		\$	\$		\$ 114,318	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				\$	\$		\$ 114,318	25

Facility Name & ID Number PROVENA ST. JOSEPH CENTER # 0041871 Report Period Beginning: 01/01/04 Ending: 12/31/04

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**					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
	A. Directly Facility Related																			
	Long-Term																			
1						\$	\$				\$	1								
2												2								
3												3								
4												4								
5												5								
	Working Capital																			
6												6								
7												7								
8												8								
9	TOTAL Facility Related					\$	\$			\$		9								
	B. Non-Facility Related*																			
10	Provena Senior Services										178,246	10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related					\$	\$			\$	178,246	14								
15	TOTALS (line 9+line14)					\$	\$			\$	178,246	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number **PROVENA ST. JOSEPH CENTER**# **0041871** Report Period Beginning: **01/01/04** Ending: **12/31/04****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

		Important , 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
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 2004 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:		1999	_____	8	
		2000	_____	9	
		2001	_____	10	
		2002	_____	11	
		2003	_____	12	
FOR OHF USE ONLY					
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 ST. JOSEPH CENTER COUNTY STEPHENSON

FACILITY IDPH LICENSE NUMBER 0041871

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 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. _____	_____	\$ _____	\$ _____
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 & 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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 51,080 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

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				\$	1
2					2
3	TOTALS			\$	3

Facility Name & ID Number PROVENA ST. JOSEPH CENTER

0041871

Report Period Beginning:

01/01/04

Ending:

12/31/04

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	120	1996	1994	\$ 2,500,000	\$ 62,500	40	\$ 62,500	\$	\$ 531,250
5									
6									
7									
8									
Improvement Type**									
9	VARIOUS	1997		33,624	1,486	8	1,486		24,232
10	VARIOUS	1998		15,953	372	6	372		14,651
11	VARIOUS	1999		80,775	5,851	11	5,851		33,114
12	VARIOUS	2000		21,185	3,633	6	3,633		16,350
13									
14	DESC: ALARM RELAYS, SWITCHES, ETC	2001		2,372	474	5	474		1,660
15	DESC: RGB ARCHITECTURAL SERVICES	2001		2,165	433	5	433		1,516
16	DESC: RGB ARCHITECTURAL SERVICES (4/27/01)	2001		45	8	3	8		45
17	DESC: BATHROOM/KITCHEN REMODELING	2001		5,246	262	20	262		918
18	DESC: WATER SOFTENER REPLACEMENT	2001		5,642	564	10	564		1,975
19	DESC: REPLACE WATER SERVICE - SLA HOUSE	2001		932	186	5	186		652
20	DESC: NEW WATER MAIN FOR ADC, OLD LINE WAS	2001		6,339	1,268	5	1,268		4,437
21	DESC: PATCH HOLE	2001		1,542	308	5	308		1,080
22	DESC: BLACKTOP WORK	2001		2,650	442	3	442		2,650
23	DESC: STEAM LINE REPAIRED	2001		1,793	359	5	359		1,255
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
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

STATE OF ILLINOIS

Page 12A

Facility Name & ID Number PROVENA ST. JOSEPH CENTER

0041871

Report Period Beginning:

01/01/04

Ending:

12/31/04

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		\$	\$		\$	\$	\$		37
38	DESC: DRYER	2002	3,295	659	5	659		1,648	38
39	DESC: ADULT ALL-ADJ STAND-IN TBL	2002	867	58	15	58		144	39
40	DESC: 200 AMP	2002	11,750	1,175	10	1,175		2,938	40
41	DESC: PLUMBING SUPPLIES FOR NEW BATHROOM	2002	425	28	15	28		57	41
42	DESC: BATHROOM REMODELING	2002	2,366	158	15	158		315	42
43	DESC: CARPETING FOR BEDROOD AND DINING ROO	2002	672	134	5	134		336	43
44	DESC: DRAPES	2002	15,414	3,083	5	3,083		7,707	44
45	DESC: ROOF REPAIR	2002	1,800	180	10	180		360	45
46	DESC: REPLACEMENT OF BRICKS ON HANDICAP RA	2002	2,055	103	20	103		257	46
47	DESC: KITCHEN CABINETS AND WALL BOARD	2002	5,260	351	15	351		877	47
48	DESC: CABINETS AND COUNTER TOPS	2002	1,105	74	15	74		184	48
49	DESC: PAINT & MISC SUPPLIES FOR REMODELING	2002	800	160	5	160		400	49
50	DESC: CARPETING ADULT DAY CARE OFFICE	2002	477	95	5	95		239	50
51	DESC: REPLACEMENT OF DAMAGED STREAM PIPES	2002	2,497	166	15	166		333	51
52									52
53	DESC: INSTALLATION OF AWNING	2003	2,950	295	10	295		443	53
54	DESC: INSTALLATION OF ELECTRIC BASEBOARD H	2003	751	75	10	75		113	54
55	DESC: DUCTLESS SPLIT SYSTEM FOR O'NEILL HA	2003	11,700	780	15	780		1,170	55
56	DESC: DURO LASST ROOFING SYSTEM	2003			10				56
57	DESC: 4 FT IRON FENCE	2003	2,526	168	15	168		253	57
58	DESC: DURO-LAST ROOFING SYSTEM	2003	21,167	2,117	10	2,117		3,175	58
59	DESC: SAWCUTTING OF CONCRETE ROOFING	2003	300	60	5	60		90	59
60	DESC: VINYL POCKET REPLACEMENT	2003	2,343	469	5	469		703	60
61	DESC: A/C COMPRESSOR	2003	3,583	299	12	299		448	61
62	DESC: TRINITY HOUSE ROOF	2003	7,125	713	10	713		1,069	62
63	DESC: VINYL WINDOW REPLACEMENTS	2003	2,943	420	7	420		631	63
64	DESC: BOILER REPLACEMENT	2003	2,227	111	20	111		111	64
65	DESC: REBUILD HIP & RAFTERS ON FRONT PORCH	2003	5,598	560	10	560		840	65
66	DESC: REWIRE 2ND FLOOR OF O'NIELL HALL	2003	12,500	1,250	10	1,250		1,875	66
67	DESC: UPGRADE SERVICE FOR VILLA HOME	2003	3,250	325	10	325		488	67
68	DESC: ROOF REMOVAL	2003	4,000	400	10	400		600	68
69	DESC: CLF BATH AND SHOWER UPGRADE	2003	1,414	141	10	141		141	69
70	TOTAL (lines 4 thru 69)		\$ 2,813,421	\$ 92,753		\$ 92,753	\$	\$ 663,726	70

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

STATE OF ILLINOIS

Facility Name & ID Number **PROVENA ST. JOSEPH CENTER**

0041871

Report Period Beginning:

01/01/04

Ending:

Page 12B

12/31/04

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	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 2,813,421	\$ 92,753		\$ 92,753	\$	\$ 663,726	1
2									2
3	DESC: BOILER REPAIR	2004	1,766	88	10	177	88	177	3
4	DESC: BOILER REPAIR	2004	1,355	45	15	90	45	90	4
5	DESC: BOILER REPAIR	2004	1,015	51	10	102	51	102	5
6	DESC: PLASTER WORK IN LARGE CHAPEL	2004	5,150	258	10	515	258	515	6
7	DESC: PAINTING OF CHAPEL	2004	9,500	950	5	1,900	950	1,900	7
8	DESC: HEAT EXCHANGE FOR MAIN BOILER	2004	4,983	249	10	498	249	498	8
9	DESC: TELEPHONE SYSTEM	2004	5,303	265	10	530	265	530	9
10	DESC: CARPET AND LABOR	2004	7,030	703	5	1,406	703	1,406	10
11	DESC: ADD SPRINKLER TO STORAGE ROOM	2004	1,680	56	15	112	56	112	11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,851,203	\$ 95,418		\$ 98,083	\$ 2,665	\$ 669,056	34

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

Facility Name & ID Number PROVENA ST. JOSEPH CENTER

0041871

Report Period Beginning:

01/01/04

Ending:

12/31/04

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	\$ 616,871	\$ 69,082	\$ 69,082	\$	8	\$ 446,513	71
72	Current Year Purchases	121,808	7,432	14,865	7,432	9	14,865	72
73	Fully Depreciated Assets	32,722					32,722	73
74	Home Office Allocation			64,639	64,639			74
75	TOTALS	\$ 771,400	\$ 76,515	\$ 148,586	\$ 72,071		\$ 494,099	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	Resident Transport	2001 Mercury Sable	2001	\$ 23,123	\$ 3,854	\$ 3,854	\$	3	\$ 23,123	76
77		1997 Dodge 2500	1997	24,090				5	24,090	77
78		Ford Turtle Top Van	2004	34,275	4,284	8,569	4,284	4	8,569	78
79										79
80	TOTALS			\$ 81,488	\$ 8,138	\$ 12,423	\$ 4,284		\$ 55,782	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)	\$ 3,704,092	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 180,071	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 259,092	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 79,021	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,218,937	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	Allocation - Home Office				14,602			5
6								6
7	TOTAL				\$ 14,602			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: \$ 26,404 Description: Nursing - \$20,473.31, Admin - \$4,451.55, Home Office - \$1,479
 (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	<u>N/A</u>		\$	\$	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.

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>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</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>2. CLASSROOM PORTION:</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>3. CLINICAL PORTION:</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	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 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)	
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 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	\$	1,090	\$ 56,889						1,090	\$ 56,889	1
2	Licensed Speech and Language Development Therapist	10a, 3	hrs		86	4,503						86	4,503	2
3	Licensed Recreational Therapist		hrs											3
4	Licensed Physical Therapist	10a, 3	hrs		1,160	60,553						1,160	60,553	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							114,318			114,318	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	TOTAL			\$	2,336	\$ 121,945				\$ 114,318		2,336	\$ 236,263	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.

Facility Name & ID Number PROVENA ST. JOSEPH CENTER

0041871

Report Period Beginning: 01/01/04

Ending:

12/31/04

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/04

(last day of reporting year)

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

	1	2	
	Operating	After Consolidation*	
A. Current Assets			
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
TOTAL Current Assets (sum of lines 1 thru 9)	\$ 18,129,236	\$	10
B. Long-Term Assets			
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): Goodwill	140,712		23
TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 62,539,176	\$	24
TOTAL ASSETS (sum of lines 10 and 24)	\$ 80,668,412	\$	25

	1	2	
	Operating	After Consolidation*	
C. Current Liabilities			
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
Other Current Liabilities(specify):			
36 Due to Related Party	988,855		36
37			37
TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 6,536,070	\$	38
D. Long-Term Liabilities			
39 Long-Term Notes Payable	1,363,410		39
40 Mortgage Payable			40
41 Bonds Payable			41
42 Deferred Compensation	143,623		42
Other Long-Term Liabilities(specify):			
43			43
44			44
TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,507,033	\$	45
TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 8,043,103	\$	46
47 TOTAL EQUITY(page 18, line 24)	\$ 72,625,309	\$	47
TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 80,668,412	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 31,464,506	1
2	Restatements (describe):		2
3			3
4	Adj. To Reconcile Consolidated Equity and Consolidated		4
5	Net Income to Nursing Facility Amounts	515,956	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 31,980,462	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	38,521	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 38,521	17
	B. Transfers (Itemize):		
18	Transfer Debt to Provena Health	40,606,326	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 40,606,326	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 72,625,309	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number PROVENA ST. JOSEPH CENTER

0041871

Report Period Beginning: 01/01/04

Ending: 12/31/04

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	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 5,060,406	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,060,406	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	234,971	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 234,971	8
C. Other Operating Revenue			
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	41,478	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	126,232	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 167,710	23
D. Non-Operating Revenue			
24	Contributions	98,305	24
25	Interest and Other Investment Income***	2,095	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 100,400	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc. Transportation	4,873	28
28a	Purchase Rebates	8,902	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 13,775	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,577,262	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,248,001	31
32	Health Care	2,243,044	32
33	General Administration	1,657,302	33
B. Capital Expense			
34	Ownership	210,196	34
C. Ancillary Expense			
35	Special Cost Centers	114,318	35
36	Provider Participation Fee	65,880	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,538,741	40
41	Income before Income Taxes (line 30 minus line 40)**	38,521	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 38,521	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 ST. JOSEPH CENTER**

0041871

Report Period Beginning: **01/01/04**

Ending:

12/31/04

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	1,952	2,160	\$ 56,716	\$ 26.26	1
2	Assistant Director of Nursing	1,960	2,160	47,200	21.85	2
3	Registered Nurses	17,063	18,616	436,845	23.47	3
4	Licensed Practical Nurses	25,287	26,983	480,079	17.79	4
5	Nurse Aides & Orderlies	73,672	79,617	675,491	8.48	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,677	5,054	52,171	10.32	8
9	Activity Director	1,966	2,170	27,221	12.54	9
10	Activity Assistants	3,838	4,195	35,796	8.53	10
11	Social Service Workers	3,757	4,183	55,790	13.34	11
12	Dietician	1,928	2,160	37,897	17.54	12
13	Food Service Supervisor	2,299	2,520	26,182	10.39	13
14	Head Cook	7,671	8,310	73,202	8.81	14
15	Cook Helpers/Assistants	20,046	21,233	147,934	6.97	15
16	Dishwashers					16
17	Maintenance Workers	8,162	8,756	87,164	9.95	17
18	Housekeepers	10,027	10,955	81,166	7.41	18
19	Laundry	11,706	13,223	105,114	7.95	19
20	Administrator	1,824	2,160	75,434	34.92	20
21	Assistant Administrator					21
22	Other Administrative	1,678	1,925	20,731	10.77	22
23	Office Manager					23
24	Clerical	6,097	6,546	70,466	10.76	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/Developm</u>	2,520	2,774	33,236	11.98	33
34	TOTAL (lines 1 - 33)	208,130	225,700	\$ 2,625,835 *	\$ 11.63	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	227	\$ 11,801	1,3	35
36	Medical Director	\$1000/mth	12,075	9,3	36
37	Medical Records Consultant	19	1,105	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	18	969	11,3	44
45	Social Service Consultant	19	1,093	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	283	\$ 27,042		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	9	\$ 264	10,3	50
51	Licensed Practical Nurses	192	6,126	10,3	51
52	Nurse Aides	50	1,231	10,3	52
53	TOTAL (lines 50 - 52)	250	\$ 7,621		53

Facility Name & ID Number PROVENA ST. JOSEPH CENTER# 0041871Report Period Beginning: 01/01/04Ending: 12/31/04**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. 5135 - Life Service 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? 120
- (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. \$ 10,415 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. \$ 65,880
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? Yes Indicate the amount. \$ 41,478
- (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 yet issued
- (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? N/A
Attach invoices and a summary of services for all architect and appraisal fees.