

		FOR BHF USE					

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2006
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2006)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0041046

Facility Name: Provena Cor Mariae Center

Address: 3330 Maria Linden Drive Rockford 61114
 Number City Zip Code

County: Winnebago

Telephone Number: (815) 877-7416 **Fax #** (815) 877-4299

HFS ID Number: 371127787013

Date of Initial License for Current Owners: 06/01/95

Type of Ownership:

<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 _____	

In the event there are further questions about this report, please contact:
Name: Lynda Olinski **Telephone Number:** (708) 478-7916

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/06 to 12/31/06 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed) _____	(Date) _____
	(Type or Print Name) <u>Michael R. Gordon</u>	
	(Title) <u>VP of Finance, CFO</u>	
Paid Preparer	(Signed) _____	(Date) _____
	(Print Name and Title) _____	
	(Firm Name & Address) _____	
	(Telephone) () _____ Fax # () _____	

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
 201 S. Grand Avenue East
 Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Provena Cor Mariae Center

0041046 Report Period Beginning: 01/01/06 Ending: 12/31/06

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>73</u>	Skilled (SNF)	<u>73</u>	<u>26,645</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>32,485</u>	5
6		ICF/DD 16 or Less			6
7	<u>162</u>	TOTALS	<u>162</u>	<u>59,130</u>	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				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>3,762</u>	<u>9,621</u>	<u>11,225</u>	<u>24,608</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC		<u>26,119</u>		<u>26,119</u>	12
13	DD 16 OR LESS					13
14	TOTALS	<u>3,762</u>	<u>35,740</u>	<u>11,225</u>	<u>50,727</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.79%

D. How many bed-hold days during this year were paid by the Department?

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

N/A - None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

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 6/5/1995

J. Was the facility purchased or leased after January 1, 1978?

YES Date 06/05/1995 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 73 and days of care provided 9,263

Medicare Intermediary Administar Federal

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 12/31/06 Fiscal Year: 12/31/06

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

Facility Name & ID Number Provena Cor Mariae Center # 0041046 Report Period Beginning: 01/01/06 Ending: 12/31/06

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	378,725	91,118	21,327	491,170		491,170		491,170			1
2	Food Purchase		308,365		308,365		308,365	4,075	312,440			2
3	Housekeeping	137,400	27,725	165	165,290		165,290		165,290			3
4	Laundry	59,526	15,373		74,899		74,899		74,899			4
5	Heat and Other Utilities			263,076	263,076		263,076	1,405	264,481			5
6	Maintenance	117,495	43,504	66,082	227,081		227,081	40,083	267,164			6
7	Other (specify):* Pastoral Care	28,307	1,551	17,935	47,793		47,793	(3,768)	44,025			7
8	TOTAL General Services	721,453	487,636	368,585	1,577,674		1,577,674	41,795	1,619,469			8
	B. Health Care and Programs											
9	Medical Director			22,750	22,750		22,750		22,750			9
10	Nursing and Medical Records	2,015,103	185,140	263,593	2,463,836		2,463,836		2,463,836			10
10a	Therapy			844,570	844,570		844,570		844,570			10a
11	Activities	258,955	13,757	11,524	284,236		284,236	1,620	285,856			11
12	Social Services	85,698	274	375	86,347		86,347		86,347			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,359,756	199,171	1,142,812	3,701,739		3,701,739	1,620	3,703,359			16
	C. General Administration											
17	Administrative	313,837	40,318	866,400	1,220,555		1,220,555	(461,311)	759,244			17
18	Directors Fees											18
19	Professional Services			24,871	24,871		24,871	263,043	287,914			19
20	Dues, Fees, Subscriptions & Promotions			94,325	94,325		94,325	(63,212)	31,113			20
21	Clerical & General Office Expenses			104,559	104,559		104,559	(206,085)	(101,526)			21
22	Employee Benefits & Payroll Taxes			774,097	774,097		774,097	125,920	900,017			22
23	Inservice Training & Education			9,946	9,946		9,946	4,893	14,839			23
24	Travel and Seminar			11,624	11,624		11,624	7,361	18,985			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			115,140	115,140		115,140	181	115,321			26
27	Other (specify):* Bad Debt			258,770	258,770		258,770	(258,770)				27
28	TOTAL General Administration	313,837	40,318	2,259,732	2,613,887		2,613,887	(587,980)	2,025,907			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,395,046	727,125	3,771,129	7,893,300		7,893,300	(544,565)	7,348,735			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 Cor Mariae Center

#0041046

Report Period Beginning:

01/01/06

Ending:

12/31/06

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			363,054	363,054	363,054	92,085	455,139				30
31	Amortization of Pre-Op. & Org.											31
32	Interest						219,827	219,827				32
33	Real Estate Taxes			840	840	840		840				33
34	Rent-Facility & Grounds						17,712	17,712				34
35	Rent-Equipment & Vehicles			13,298	13,298	13,298	1,593	14,891				35
36	Other (specify):*											36
37	TOTAL Ownership			377,192	377,192	377,192	331,217	708,409				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			606,198	606,198	606,198		606,198				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			38,618	38,618	38,618		38,618				42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			644,816	644,816	644,816		644,816				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,395,046	727,125	4,793,137	8,915,308	8,915,308	(213,348)	8,701,960				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: 01/01/06

Ending: 12/31/06

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				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	12,314	30		9
10	Interest and Other Investment Income	(13,044)	32		10
11	Discounts, Allowances, Rebates & Refunds	(217,864)	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	(258,770)	27		24
25	Fund Raising, Advertising and Promotional	(72,617)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (549,981)		\$	30

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)	340,401		34
35	Other- Attach Schedule	(3,768)		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 336,633		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (213,348)		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

BHF USE ONLY					
48		49		50	51
					52

Provena Cor Mariae Center

ID# 0041046

Report Period Beginning: 01/01/06

Ending: 12/31/06

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Development Office Supplies	\$ (544)	7	1
2	Development Misc.	(3,224)	7	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(3,768)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Provena Cor Mariae Center

0041046

Report Period Beginning:

01/01/06

Ending:

12/31/06

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	0	4,075	0	0	0	0	0	0	0	0	0	4,075	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	1,405	0	0	0	0	0	0	0	0	0	1,405	5
6	Maintenance	0	278	39,805	0	0	0	0	0	0	0	0	40,083	6
7	Other (specify):*	(3,768)	0	0	0	0	0	0	0	0	0	0	(3,768)	7
8	TOTAL General Services	(3,768)	5,758	39,805	0	41,795	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	1,620	0	0	0	0	0	0	0	0	0	1,620	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	1,620	0	0	0	0	0	0	0	0	0	1,620	16
	C. General Administration													
17	Administrative	0	(395,965)	(65,346)	0	0	0	0	0	0	0	0	(461,311)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	38,112	224,931	0	0	0	0	0	0	0	0	263,043	19
20	Fees, Subscriptions & Promotions	(72,617)	9,405	0	0	0	0	0	0	0	0	0	(63,212)	20
21	Clerical & General Office Expenses	(217,864)	11,779	0	0	0	0	0	0	0	0	0	(206,085)	21
22	Employee Benefits & Payroll Taxes	0	61,156	64,764	0	0	0	0	0	0	0	0	125,920	22
23	Inservice Training & Education	0	4,893	0	0	0	0	0	0	0	0	0	4,893	23
24	Travel and Seminar	0	7,361	0	0	0	0	0	0	0	0	0	7,361	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	181	0	0	0	0	0	0	0	0	0	181	26
27	Other (specify):*	(258,770)	0	0	0	0	0	0	0	0	0	0	(258,770)	27
28	TOTAL General Administration	(549,251)	(263,078)	224,349	0	(587,980)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(553,019)	(255,700)	264,154	0	(544,565)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Provena Cor Mariae Center

0041046

Report Period Beginning:

01/01/06 Ending:

12/31/06

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	12,314	0	79,771	0	0	0	0	0	0	0	0	92,085	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(13,044)	0	232,871	0	0	0	0	0	0	0	0	219,827	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	17,712	0	0	0	0	0	0	0	0	17,712	34
35	Rent-Equipment & Vehicles	0	0	1,593	0	0	0	0	0	0	0	0	1,593	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(730)	0	331,947	0	331,217	37							
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(553,749)	(255,700)	596,101	0	(213,348)	45							

Facility Name & ID Number Provena Cor Mariae Center

0041046

Report Period Beginning:

01/01/06

Ending:

12/31/06

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%	\$ 4,075	\$ 4,075 1
2	V	5 Utilities		Provena Senior Services	100.00%	1,405	1,405 2
3	V	6 Maintenance - Other		Provena Senior Services	100.00%	278	278 3
4	V	11 Activities-Special Events		Provena Senior Services	100.00%	1,620	1,620 4
5	V	17 Admin - Misc. Other	635,160	Provena Senior Services	100.00%	13,257	(621,903) 5
6	V	17 Administrative Salaries		Provena Senior Services	100.00%	225,938	225,938 6
7	V	19 Professional Services		Provena Senior Services	100.00%	38,112	38,112 7
8	V	20 Dues,Subscriptions		Provena Senior Services	100.00%	9,405	9,405 8
9	V	21 Clerical Supplies		Provena Senior Services	100.00%	11,779	11,779 9
10	V	22 Employee Benefits		Provena Senior Services	100.00%	61,156	61,156 10
11	V	23 Education/Conference		Provena Senior Services	100.00%	4,893	4,893 11
12	V	24 Travel		Provena Senior Services	100.00%	7,361	7,361 12
13	V	26 Insurance		Provena Senior Services	100.00%	181	181 13
14	Total		\$ 635,160			\$ 379,460	\$ * (255,700) 14

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

Facility Name & ID Number Provena Cor Mariae Center# 0041046Report Period Beginning: 01/01/06Ending: 12/31/06

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	30 Depreciation	\$	Provena Senior Services	100.00%	\$ 3,633	\$ 3,633	15
16	V	32 Interest		Provena Senior Services	100.00%	232,871	232,871	16
17	V	34 Rent - Facility		Provena Senior Services	100.00%	17,712	17,712	17
18	V	35 Rent - Equipment		Provena Senior Services	100.00%	1,593	1,593	18
19	V	17 Admin Salaries	110,640	Provena Health Services	100.00%	70,112	(40,528)	19
20	V	22 Employee Benefits		Provena Health Services	100.00%	27,371	27,371	20
21	V	30 Depreciation		Provena Health Services	100.00%	76,138	76,138	21
22	V	19 Admin Consulting,Other		Provena Health Services	100.00%	224,931	224,931	22
23	V	17 Information Systems Salaries	120,600	Provena Health Services	100.00%	16,989	(103,611)	23
24	V	22 Information Systems Benefits		Provena Health Services	100.00%	6,633	6,633	24
25	V	6 Information Systems - Equip Maint		Provena Health Services	100.00%	10,953	10,953	25
26	V	17 Admin Salaries		Provena Health Services	100.00%	47,129	47,129	26
27	V	22 Employee Benefits		Provena Health Services	100.00%	18,399	18,399	27
28	V	17 Information Systems Salaries		Provena Health Services	100.00%	31,664	31,664	28
29	V	22 Information Systems Benefits		Provena Health Services	100.00%	12,361	12,361	29
30	V	6 Information Systems - Equip Maint		Provena Health Services	100.00%	28,852	28,852	30
31	V	39 Ancillary Services - Other	606,198	Provena Senior Services Pharmacy	100.00%	606,198		31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 837,438			\$ 1,433,539	\$ * 596,101	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: 01/01/06 Ending: 12/31/06

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 Cor Mariae Center

0041046

Report Period Beginning:

01/01/06

Ending: 12/31/06

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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	2	Food	Management Fee Income 5,596,693	20	\$ 35,910	\$	635,160	\$ 4,075	1
2	5	Utilities	Management Fee Income 5,596,693	20	12,383		635,160	1,405	2
3	6	Maintenance - Other	Management Fee Income 5,596,693	20	2,446		635,160	278	3
4	11	Activities-Special Events	Management Fee Income 5,596,693	20	14,275		635,160	1,620	4
5	17	Admin - Misc. Other	Management Fee Income 5,596,693	20	116,818		635,160	13,257	5
6	17	Administrative Salaries	Management Fee Income 5,596,693	20	1,990,843	1,990,843	635,160	225,938	6
7	19	Professional Services	Management Fee Income 5,596,693	20	335,820		635,160	38,112	7
8	20	Dues,Subscriptions	Management Fee Income 5,596,693	20	82,869		635,160	9,405	8
9	21	Clerical Supplies	Management Fee Income 5,596,693	20	103,786		635,160	11,779	9
10	22	Employee Benefits	Management Fee Income 5,596,693	20	538,870		635,160	61,156	10
11	23	Education/Conference	Management Fee Income 5,596,693	20	43,116		635,160	4,893	11
12	24	Travel	Management Fee Income 5,596,693	20	64,864		635,160	7,361	12
13	26	Insurance	Management Fee Income 5,596,693	20	1,591		635,160	181	13
14	30	Depreciation	Management Fee Income 5,596,693	20	32,015		635,160	3,633	14
15	32	Interest	Management Fee Income 5,596,693	20	2,051,940		635,160	232,871	15
16	34	Rent - Facility	Management Fee Income 5,596,693	20	156,067		635,160	17,712	16
17	35	Rent - Equipment	Management Fee Income 5,596,693	20	14,036		635,160	1,593	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 5,597,649	\$ 1,990,843		\$ 635,269	25

Facility Name & ID Number Provena Cor Mariae Center

0041046

Report Period Beginning:

01/01/06

Ending: 12/31/06

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

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

Name of Related Organization Provena Health Services
 Street Address 9223 West St. Francis Road
 City / State / Zip Code Frankfort, IL 60423
 Phone Number (815)469-4888
 Fax Number (815)469-4864

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	17	Admin Salaries	Operating Expense	1,192,116	10	\$ 755,436	\$ 755,436	110,640	\$ 70,112	1
2	22	Employee Benefits	Operating Expense	1,192,116	10	294,918		110,640	27,371	2
3	30	Depreciation	Operating Expense	1,192,116	10	820,363		110,640	76,138	3
4	19	Admin Consulting,Other	Operating Expense	1,192,116	10	2,423,574		110,640	224,931	4
5	17	Information Systems Salaries	Operating Expense	1,301,820	10	183,390	183,390	120,600	16,989	5
6	22	Information Systems Benefits	Operating Expense	1,301,820	10	71,595		120,600	6,633	6
7	6	Information Systems - Equip Main	Operating Expense	1,301,820	10	118,233		120,600	10,953	7
8	17	Admin Salaries	Direct Cost	1,192,116	10	507,799	507,799	110,640	47,129	8
9	22	Employee Benefits	Direct Cost	1,192,116	10	198,242		110,640	18,399	9
10	17	Information Systems Salaries	Direct Cost	1,301,820	10	341,798	341,798	120,600	31,664	10
11	22	Information Systems Benefits	Direct Cost	1,301,820	10	133,436		120,600	12,361	11
12	6	Information Systems - Equip Main	Direct Cost	1,301,820	10	311,444		120,600	28,852	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					\$ 6,160,228	\$ 1,788,423		\$ 571,532	25

Facility Name & ID Number Provena Cor Mariae Center

0041046

Report Period Beginning:

01/01/06

Ending: 12/31/06

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	39	Ancillary Services - Other	Direct Allocation		\$	\$		\$ 606,198	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				\$	\$		\$ 606,198	25

Facility Name & ID Number Provena Cor Mariae Center # 0041046 Report Period Beginning: 01/01/06 Ending: 12/31/06

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									219,827	10									
11										11										
12										12										
13										13										
14	TOTAL Non-Facility Related					\$	\$		\$	219,827	14									
15	TOTALS (line 9+line14)					\$	\$		\$	219,827	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.)

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

B. Real Estate Taxes

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>			
1. Real Estate Tax accrual used on 2005 report.		\$ 2,093	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.)		\$ 1,086	2
3. Under or (over) accrual (line 2 minus line 1).		\$ (1,007)	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 1,847	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.		\$ 840	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2001	942	8
	2002		9
	2003	974	10
	2004	1,038	11
	2005	1,086	12
	FOR BHF USE ONLY		
	13	FROM R. E. TAX STATEMENT FOR 2005 \$	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:** 2005 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 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 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 Bureau of Health Finance at (217) 782-1630.

2005 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 2005 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 2005.

(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>1,086.20</u>	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u>1,086.20</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 X 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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

PLEASE NOTE: Payment information from the Internet or otherwise is not considered acceptable tax bill documentation. Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number Provena Cor Mariae Center

0041046 Report Period Beginning:

01/01/06 Ending:

12/31/06

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 115,889 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, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES 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	<u>Nursing Home</u>		<u>1995</u>	<u>\$ 670,894</u>	1
2					2
3	TOTALS			\$ 670,894	3

Facility Name & ID Number Provena Cor Mariae Center

0041046

Report Period Beginning:

01/01/06

Ending:

12/31/06

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 BHF 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	\$ 33,333	20	\$ 33,333		\$ 383,333	4
5	63			1997	2,508,246	62,711	40	62,711		579,882	5
6	10			2005	955,153	38,384	25	38,384		55,720	6
7											7
8											8
	Improvement Type**										
9	Various			1995	166,756	6,588	15	6,588		108,271	9
10	Various			1996	154,526	8,382	15	8,382		101,213	10
11	Various			1997	515,025	24,768	15	24,768		286,245	11
12	Various			1998	175,915	5,239	30	5,239		63,273	12
13	Various			1999	10,976	45	10	45		10,864	13
14	Various			2000	47,412	1,176	10	1,176		43,296	14
15	Various			2001	50,678	4,233	9	4,233		27,119	15
16	Various			2002	118,018	10,472	10	10,472		45,706	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

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

Facility Name & ID Number Provena Cor Mariae Center

0041046

Report Period Beginning:

01/01/06

Ending:

12/31/06

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	\$	\$ 599	37
38	DESC: JOCKEY PUMP AND CONTROLLER	2003	3,340	167	20	167		585	38
39	DESC: REROOFING	2003	5,325	533	10	533		1,864	39
40	DESC: CARPET INSTALLATION	2003	1,937	387	5	387		1,356	40
41	DESC: FREEZER REPAIR	2003	1,726	345	5	345		1,208	41
42	DESC: REPAIR SHOWER FLOOR	2003	744	74	10	74		260	42
43	DESC: REPLACE BOILER SHEET METAL STACK	2003	2,560	128	20	128		448	43
44	DESC: COUNTER TOPS FOR THERAPY KITCHEN ARE	2003	1,103	110	10	110		386	44
45	DESC: COMPRESSOR FOR FREEZER	2003	584	58	10	58		205	45
46	DESC: REPAIR OUTSIDE LIGHTS	2003	2,369	158	15	158		474	46
47	DESC: ALARM SYSTEM	2003	11,753	1,175	10	1,175		4,114	47
48	DESC: CARPET INSTALLATION	2003	90,500	18,100	5	18,100		54,300	48
49	DESC: DOOR OPERATOR FOR MAIN ENTRANCE	2003	2,157	216	10	216		647	49
50	DESC: CODE ALERT SYSTEM	2003	4,700	470	10	470		1,645	50
51	DESC: ROOF REPLACEMENT	2003	38,000	3,800	10	3,800		11,400	51
52									52
53	DESC: TOSHIBA CTX670 TELEPHONE SYSTEM	2004	33,116	3,312	10	3,312		8,279	53
54	DESC: REPAIR WATERMAIN	2004	2,712	181	15	181		452	54
55	DESC: FRENCH DOORS	2004	4,000	267	15	267		667	55
56	DESC: WATER MAIN REPAIR	2004	6,819	455	15	455		1,137	56
57	DESC: EXTRACTION OF WATER - WATER DAMAGE	2004	1,040	208	5	208		520	57
58	DESC: PLAN BIDDING AND NEGOTIATION	2004	3,187	637	5	637		1,593	58
59	DESC: SAW AND PATCH	2004	2,494	499	5	499		1,247	59
60	DESC: SEAL & STRIPING OF PARKING LOTS	2004	7,008	1,402	5	1,402		3,504	60
61	DESC: DRAFTING OF DESIGN DRAWINGS - SNF AD	2004	610	122	5	122		305	61
62	DESC: CALL LIGHT ITMING SYSTEM FOR SKILLED	2004	4,208	421	10	421		1,052	62
63	DESC: UPGRADE KIT FOR SURFACE CODE ALERT U	2004	733	147	5	147		367	63
64	DESC: INSTALL BURN THROW DOOR	2004	818	82	10	82		164	64
65	DESC: REROOF MAINTENANCE SHOP	2004	21,947	2,195	10	2,195		4,389	65
66	DESC: MVP WATER SOFTENER	2004	1,658	166	10	166		332	66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 5,996,562	\$ 231,316		\$ 231,316	\$	\$ 1,808,419	70

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

Facility Name & ID Number Provena Cor Mariae Center

0041046

Report Period Beginning:

01/01/06

Ending:

12/31/06

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	
1	Totals from Page 12A, Carried Forward		\$ 5,996,562	\$ 231,316		\$ 231,316	\$	\$ 1,808,419	1
2	DESC: RELOCATION OF UNDERGROUND CABLE FOR	2005	5,736	382	15	382		574	2
3	DESC: PARTS/LABOR TO REPLACE WATER DAMAGED	2005	5,730	573	10	573		860	3
4	DESC: TEKNOFLOR IN SKILLED NURSES STATION	2005	2,170	310	7	310		465	4
5	DESC: EXTERNAL SIGNAGE	2005	3,000	300	10	300		450	5
6	DESC: LANDSCAPING	2005	5,950	595	10	595		893	6
7	DESC: SIGNAGE	2005	1,914	191	10	191		287	7
8	DESC: TEKNOFLOR#73803 SHEET VINYL AND VINYL	2005	8,780	878	10	878		1,317	8
9	DESC: WATERMAIN REPAIR	2005	3,512	351	10	351		351	9
10									10
11	DESC: FENCING INSTALLATION	2006	35,687	1,487	12	2,974	1,487	1,487	11
12	DESC: PATIO ROOF /FRONT ENTRANCE ROOF	2006	42,366	2,118	10	4,237	2,119	2,118	12
13	DESC: COOLING TOWER REPLACEMENT	2006	33,800	1,127	15	2,253	1,126	1,127	13
14	DESC: FAS 47 ACCRUAL	2006		13,174		13,174		13,174	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)		\$ 6,145,208	\$ 252,802		\$ 257,534	\$ 4,732	\$ 1,831,520	34

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

Facility Name & ID Number Provena Cor Mariae Center # 0041046 Report Period Beginning: 01/01/06 Ending: 12/31/06

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	\$ 1,316,417	\$ 97,478	\$ 97,478	\$	10	\$ 616,541	71
72	Current Year Purchases	179,470	8,523	17,047	8,523	10	17,047	72
73	Fully Depreciated Assets	260,405					260,405	73
74	Home office allocation		79,771	79,771				74
75	TOTALS	\$ 1,756,292	\$ 185,772	\$ 194,296	\$ 8,523		\$ 893,992	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	2000 Ford Eldorado	2000	\$ 42,500	\$ 4,250	\$ 4,250	\$	10	\$ 27,625	76
77	Plant Engineering	1991 Chevy Pickup	1995	14,000				5	14,000	77
78		Noncare Portion	2001	(15,062)		(941)	(941)		(11,765)	78
79										79
80	TOTALS			\$ 41,438	\$ 4,250	\$ 3,309	\$ (941)		\$ 29,860	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)		\$ 8,613,832	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 442,825	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 455,139	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$ 12,314	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 2,755,372	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: _____

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				17,712			5
6					_____			6
7	TOTAL				\$ 17,712			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.	_____ /2007	\$ _____
13.	_____ /2008	\$ _____
14.	_____ /2009	\$ _____

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: \$ 106,233 Description: Nursing \$90,227, Supp Lvg \$94, Activities \$78, Plant Eng \$1,505, Admin \$12,736, Home Office \$1,593

(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	N/A		\$ _____	\$ _____	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.

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <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. <u>CLASSROOM PORTION:</u></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 CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a,3	hrs	\$	7,952	\$ 415,116	\$	7,952	\$ 415,116	1
2	Licensed Speech and Language Development Therapist	10a,3	hrs		2,472	129,035		2,472	129,035	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a,3	hrs		5,755	300,419		5,755	300,419	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				606,198		606,198	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			\$	16,179	\$ 844,570	\$ 606,198	16,179	\$ 1,450,768	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Provena Cor Mariae Center # 0041046 Report Period Beginning: 01/01/06 Ending: 12/31/06

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/06 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 9,196,621	\$	1
2	Cash-Patient Deposits	104,225		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	10,284,617		3
4	Supply Inventory (priced at)	527,496		4
5	Short-Term Investments			5
6	Prepaid Insurance	17,880		6
7	Other Prepaid Expenses	180,330		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 20,311,169	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	6,785,655		12
13	Land	6,865,930		13
14	Buildings, at Historical Cost	81,049,403		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	17,957,954		16
17	Accumulated Depreciation (book methods)	(48,335,409)		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): <u>Goodwill</u>	126,984		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 64,450,517	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 84,761,686	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 3,462,064	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,875,684		28
29	Short-Term Notes Payable	38,451		29
30	Accrued Salaries Payable	2,295,855		30
31	Accrued Taxes Payable (excluding real estate taxes)	68,182		31
32	Accrued Real Estate Taxes(Sch.IX-B)	676,390		32
33	Accrued Interest Payable	32,958		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Due to Related Party</u>	595,505		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 9,045,089	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,289,822		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	276,292		42
	Other Long-Term Liabilities(specify):			
43	<u>Conditional Asset Retirement</u>	647,900		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,214,014	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 11,259,103	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 73,502,584	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 84,761,687	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 74,753,215	1
2	Restatements (describe):		2
3	Transfer to Affiliates	(3,000,000)	3
4	Adj. To reconcile consolidated equity & consolidated income	1,183,920	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 72,937,135	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	309,252	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock	85,263	9
10	Stock Options Exercised		10
11	Contributions and Grants	381,287	11
12	Expenditures for Specific Purposes	(210,353)	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)	\$ 565,449	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 73,502,584	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Provena Cor Mariae Center# 0041046Report Period Beginning: 01/01/06Ending: 12/31/06**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	\$ 6,940,088	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,940,088	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,623,522	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,623,522	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	(3,575)	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	120,905	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	2,673	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 120,003	23
D. Non-Operating Revenue			
24	Contributions	201,384	24
25	Interest and Other Investment Income***	13,044	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 214,428	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Purchase Rebates</u>	217,864	28
28a	<u>Misc. Income</u>	108,655	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 326,519	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,224,560	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,578,515	31
32	Health Care	3,701,739	32
33	General Administration	2,613,886	33
B. Capital Expense			
34	Ownership	376,352	34
C. Ancillary Expense			
35	Special Cost Centers	606,198	35
36	Provider Participation Fee	38,618	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,915,308	40
41	Income before Income Taxes (line 30 minus line 40)**	309,252	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 309,252	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:

01/01/06

Ending:

12/31/06

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	1,664	1,834	\$ 81,620	\$ 44.50	1
2	Assistant Director of Nursing	1,968	2,080	70,168	33.73	2
3	Registered Nurses	11,084	11,475	312,911	27.27	3
4	Licensed Practical Nurses	21,677	23,252	530,873	22.83	4
5	CNAs & Orderlies	66,368	71,816	938,484	13.07	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,850	7,396	81,047	10.96	8
9	Activity Director	1,416	2,136	34,401	16.11	9
10	Activity Assistants	18,077	19,180	224,554	11.71	10
11	Social Service Workers	5,989	6,352	85,698	13.49	11
12	Dietician	1,880	2,101	31,841	15.16	12
13	Food Service Supervisor	1,566	1,593	22,125	13.89	13
14	Head Cook	8,517	9,173	111,498	12.16	14
15	Cook Helpers/Assistants	26,648	28,013	213,261	7.61	15
16	Dishwashers					16
17	Maintenance Workers	6,454	7,213	117,495	16.29	17
18	Housekeepers	15,314	16,792	137,400	8.18	18
19	Laundry	6,300	6,694	59,526	8.89	19
20	Administrator	1,816	2,080	96,780	46.53	20
21	Assistant Administrator	1,896	1,936	44,683	23.08	21
22	Other Administrative	3,316	3,802	74,175	19.51	22
23	Office Manager	1,554	1,710	29,378	17.18	23
24	Clerical	6,219	6,772	68,821	10.16	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 Care</u>	1,868	2,080	28,307	13.61	33
34	TOTAL (lines 1 - 33)	218,441	235,480	\$ 3,395,046 *	\$ 14.42	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	197	\$ 13,262	1,3	35
36	Medical Director	\$1750/mo	22,750	9,3	36
37	Medical Records Consultant	16	920	10,3	37
38	Nurse Consultant	229	18,647	10,3	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	58	3,349	11,3	44
45	Social Service Consultant	6	330	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	506	\$ 59,258		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	171	\$ 5,822	10,3	50
51	Licensed Practical Nurses	2,643	85,737	10,3	51
52	Certified Nurse Assistants/Aides	1,878	34,155	10,3	52
53	TOTAL (lines 50 - 52)	4,692	\$ 125,714		53

Facility Name & ID Number Provena Cor Mariae Center

0041046

Report Period Beginning: 01/01/06

Ending: 12/31/06

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Teresa Wester-Peters	Administrator	0	\$ 96,780	Workers' Compensation Insurance	\$ 68,640	IDPH License Fee	\$	
Administrative Staff	Admissions	0	41,777	Unemployment Compensation Insurance	12,230	Advertising: Employee Recruitment		
Administrative Staff	Human Resource	0	32,398	FICA Taxes	243,906	Health Care Worker Background Check		
Administrative Staff	Admin Asst	0	29,437	Employee Health Insurance	308,529	(Indicate # of checks performed)		
Administrative Staff	Receptionist	0	39,384	Employee Meals		Patient Background Checks		
Administrative Staff	Office Manager	0	29,378	Illinois Municipal Retirement Fund (IMRF)*		Employee Recruitment	7,448	
Administrative Staff	Asst Administrator	0	44,683	Life Insurance	18,436	Dues & Subscription	10,420	
TOTAL (agree to Schedule V, line 17, col. 1)				Pension	95,329	Advertising & Public Relations	76,457	
(List each licensed administrator separately.)			\$ 313,837	Employee Recognition	5,820			
B. Administrative - Other				Executive Benefits	6,779	Home Office Allocation	9,405	
Description			Amount	Employment Screenings	14,428	Less: Public Relations Expense	()	
Corporate Service Fee			\$ 110,640	Home Office Allocation	125,920	Non-allowable advertising	(72,617)	
Corporate Fee			120,600			Yellow page advertising	()	
Mgmt Fee			331,200	TOTAL (agree to Schedule V, line 22, col.8)			\$ 900,017	
Mngt Fee Interest			303,960					
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 866,400					
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
C. Professional Services				Description	Line #	Amount	Description	Amount
Vendor/Payee	Type		Amount	N/A		\$	Out-of-State Travel	\$
Legal Expense	Various		\$ 10,403					
Collection Expense	Various		1,153				In-State Travel	11,624
Shredding	Various		827					
Survey & Analytical Tools	Various		11,265				Seminar Expense	
Living Design	Various		345				Home Office Allocation	7,361
Outsourced Services	Various		878				Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 18,985
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			\$	
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 24,871					

* Attach copy of IMRF notifications

**See instructions.

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? 162
- (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. \$ 21,740 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 38,618
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? 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 \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.