

		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: 0042879

Facility Name: Provena McAuley Manor

Address: 400 West Sullivan Road Aurora 60506
 Number City Zip Code

County: Kane

Telephone Number: (630) 859-3700 **Fax #** (630) 264-1862

HFS ID Number: 371127787012

Date of Initial License for Current Owners: 12/01/97

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 McAuley Manor

0042879 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	87	Skilled (SNF)	87	31,755	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	87	TOTALS	87	31,755	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	1,095	12,307	9,803	23,205	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	1,095	12,307	9,803	23,205	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 73.08%

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 12/1/1997

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

YES Date _____ NO

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

YES NO If YES, enter number of beds certified 42 and days of care provided 8,713

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 McAuley Manor # 0042879 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	181,302	36,736	8,990	227,028		227,028		227,028			1
2	Food Purchase		135,655		135,655		135,655	(11,606)	124,049			2
3	Housekeeping	180,999	21,846	441	203,286		203,286		203,286			3
4	Laundry	23,434	2,713	60,741	86,888		86,888	(16,681)	70,207			4
5	Heat and Other Utilities			114,296	114,296		114,296	597	114,893			5
6	Maintenance	70,918	21,829	51,106	143,853		143,853	32,913	176,766			6
7	Other (specify):* Pastoral Care	33,365	2,440	37,511	73,316		73,316	(20,064)	53,252			7
8	TOTAL General Services	490,018	221,219	273,085	984,322		984,322	(14,841)	969,481			8
	B. Health Care and Programs											
9	Medical Director			18,196	18,196		18,196		18,196			9
10	Nursing and Medical Records	1,796,018	163,133	509,409	2,468,560		2,468,560		2,468,560			10
10a	Therapy			542,090	542,090		542,090		542,090			10a
11	Activities	59,433	1,773	14,567	75,773		75,773	689	76,462			11
12	Social Services	33,214	38	428	33,680		33,680		33,680			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,888,665	164,944	1,084,690	3,138,299		3,138,299	689	3,138,988			16
	C. General Administration											
17	Administrative	280,110	13,367	460,440	753,917		753,917	(222,162)	531,755			17
18	Directors Fees											18
19	Professional Services			169,803	169,803		169,803	201,367	371,170			19
20	Dues, Fees, Subscriptions & Promotions			42,227	42,227		42,227	(18,431)	23,796			20
21	Clerical & General Office Expenses			36,085	36,085		36,085	(181,296)	(145,211)			21
22	Employee Benefits & Payroll Taxes			562,601	562,601		562,601	79,323	641,924			22
23	Inservice Training & Education			11,421	11,421		11,421	2,080	13,501			23
24	Travel and Seminar			5,695	5,695		5,695	3,129	8,824			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			92,740	92,740		92,740	77	92,817			26
27	Other (specify):* Bad Debt			(83,651)	(83,651)		(83,651)	83,561	(90)			27
28	TOTAL General Administration	280,110	13,367	1,297,361	1,590,838		1,590,838	(52,352)	1,538,486			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,658,793	399,530	2,655,136	5,713,459		5,713,459	(66,504)	5,646,955			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 McAuley Manor #0042879 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			308,358	308,358	308,358	70,932	379,290				30
31	Amortization of Pre-Op. & Org.											31
32	Interest						95,007	95,007				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds						7,529	7,529				34
35	Rent-Equipment & Vehicles			4,548	4,548	4,548	677	5,225				35
36	Other (specify):*											36
37	TOTAL Ownership			312,906	312,906	312,906	174,145	487,051				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			649,269	649,269	649,269		649,269				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			47,633	47,633	47,633		47,633				42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			696,902	696,902	696,902		696,902				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,658,793	399,530	3,664,944	6,723,267	6,723,267	107,641	6,830,908				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 McAuley Manor

0042879

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	(13,338)	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	(16,681)	4		8
9	Non-Straightline Depreciation	6,711	30		9
10	Interest and Other Investment Income	(3,984)	32		10
11	Discounts, Allowances, Rebates & Refunds	(186,303)	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	83,561	27		24
25	Fund Raising, Advertising and Promotional	(22,429)	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)	\$ (152,463)		\$	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)	280,168		34
35	Other- Attach Schedule	(20,064)		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 260,104		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 107,641		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 McAuley Manor

ID# 0042879

Report Period Beginning: 01/01/06

Ending: 12/31/06

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Development Office Supplies	\$ (489)	7	1
2	Development Publications	(23)	7	2
3	Development Food	(291)	7	3
4	Development Travel	(30)	7	4
5	Development Misc	(19,231)	7	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	(20,064)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Provena McAuley Manor

0042879

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	(13,338)	1,732	0	0	0	0	0	0	0	0	0	(11,606)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(16,681)	0	0	0	0	0	0	0	0	0	0	(16,681)	4
5	Heat and Other Utilities	0	597	0	0	0	0	0	0	0	0	0	597	5
6	Maintenance	0	118	32,795	0	0	0	0	0	0	0	0	32,913	6
7	Other (specify):*	(20,064)	0	0	0	0	0	0	0	0	0	0	(20,064)	7
8	TOTAL General Services	(50,083)	2,447	32,795	0	(14,841)	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	689	0	0	0	0	0	0	0	0	0	689	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	689	0	0	0	0	0	0	0	0	0	689	16
	C. General Administration													
17	Administrative	0	(168,320)	(53,842)	0	0	0	0	0	0	0	0	(222,162)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	16,201	185,166	0	0	0	0	0	0	0	0	201,367	19
20	Fees, Subscriptions & Promotions	(22,429)	3,998	0	0	0	0	0	0	0	0	0	(18,431)	20
21	Clerical & General Office Expenses	(186,303)	5,007	0	0	0	0	0	0	0	0	0	(181,296)	21
22	Employee Benefits & Payroll Taxes	0	25,997	53,326	0	0	0	0	0	0	0	0	79,323	22
23	Inservice Training & Education	0	2,080	0	0	0	0	0	0	0	0	0	2,080	23
24	Travel and Seminar	0	3,129	0	0	0	0	0	0	0	0	0	3,129	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	77	0	0	0	0	0	0	0	0	0	77	26
27	Other (specify):*	83,561	0	0	0	0	0	0	0	0	0	0	83,561	27
28	TOTAL General Administration	(125,171)	(111,831)	184,650	0	(52,352)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(175,254)	(108,695)	217,445	0	(66,504)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Provena McAuley Manor

0042879

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	6,711	0	64,221	0	0	0	0	0	0	0	0	70,932	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,984)	0	98,991	0	0	0	0	0	0	0	0	95,007	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	7,529	0	0	0	0	0	0	0	0	7,529	34
35	Rent-Equipment & Vehicles	0	0	677	0	0	0	0	0	0	0	0	677	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	2,727	0	171,418	0	174,145	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)	(172,527)	(108,695)	388,863	0	107,641	45							

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: Adjustments for Related Organization Costs (7 minus 4)
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	
1	V	2 Food	\$	Provena Senior Services	100.00%	\$ 1,732	\$ 1,732 1
2	V	5 Utilities		Provena Senior Services	100.00%	597	597 2
3	V	6 Maintenance - Other		Provena Senior Services	100.00%	118	118 3
4	V	11 Activities-Special Events		Provena Senior Services	100.00%	689	689 4
5	V	17 Admin - Misc. Other	270,000	Provena Senior Services	100.00%	5,636	(264,364) 5
6	V	17 Administrative Services		Provena Senior Services	100.00%	96,044	96,044 6
7	V	19 Professional Salaries		Provena Senior Services	100.00%	16,201	16,201 7
8	V	20 Dues,Subscriptions		Provena Senior Services	100.00%	3,998	3,998 8
9	V	21 Clerical Supplies		Provena Senior Services	100.00%	5,007	5,007 9
10	V	22 Employee Benefits		Provena Senior Services	100.00%	25,997	25,997 10
11	V	23 Education/Conference		Provena Senior Services	100.00%	2,080	2,080 11
12	V	24 Travel		Provena Senior Services	100.00%	3,129	3,129 12
13	V	26 Insurance		Provena Senior Services	100.00%	77	77 13
14	Total		\$ 270,000			\$ 161,305	\$ * (108,695) 14

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

Facility Name & ID Number Provena McAuley Manor# 0042879Report 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%	\$ 1,544	\$ 1,544	15
16	V	32 Interest		Provena Senior Services	100.00%	98,991	98,991	16
17	V	34 Rent - Facility		Provena Senior Services	100.00%	7,529	7,529	17
18	V	35 Rent - Equipment		Provena Senior Services	100.00%	677	677	18
19	V	17 Admin Salaries	91,080	Provena Health Services	100.00%	57,717	(33,363)	19
20	V	22 Employee Benefits		Provena Health Services	100.00%	22,532	22,532	20
21	V	30 Depreciation		Provena Health Services	100.00%	62,677	62,677	21
22	V	19 Admin Consulting,Other		Provena Health Services	100.00%	185,166	185,166	22
23	V	17 Information Systems Salaries	99,360	Provena Health Services	100.00%	13,997	(85,363)	23
24	V	22 Information Systems Benefits		Provena Health Services	100.00%	5,464	5,464	24
25	V	6 Information Systems - Equip Maint		Provena Health Services	100.00%	9,024	9,024	25
26	V	17 Admin Salaries		Provena Health Services	100.00%	38,797	38,797	26
27	V	22 Employee Benefits		Provena Health Services	100.00%	15,146	15,146	27
28	V	17 Information Systems Salaries		Provena Health Services	100.00%	26,087	26,087	28
29	V	22 Information Systems Benefits		Provena Health Services	100.00%	10,184	10,184	29
30	V	6 Information Systems - Equip Maint		Provena Health Services	100.00%	23,771	23,771	30
31	V	39 Ancillary Services - Other	649,269	Provena Senior Services Pharmacy	100.00%	649,269		31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 839,709			\$ 1,228,572	\$ * 388,863	39

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

Facility Name & ID Number Provena McAuley Manor # 0042879 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 McAuley Manor

0042879

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 5596693	20	\$ 35,910	\$	270,000	\$ 1,732	1
2	5	Utilities	Management Fee Income 5596693	20	12,383		270,000	597	2
3	6	Maintenance - Other	Management Fee Income 5596693	20	2,446		270,000	118	3
4	11	Activities-Special Events	Management Fee Income 5596693	20	14,275		270,000	689	4
5	17	Admin - Misc. Other	Management Fee Income 5596693	20	116,818		270,000	5,636	5
6	17	Administrative Salaries	Management Fee Income 5596693	20	1,990,843	1,990,843	270,000	96,044	6
7	19	Professional Services	Management Fee Income 5596693	20	335,820		270,000	16,201	7
8	20	Dues,Subscriptions	Management Fee Income 5596693	20	82,869		270,000	3,998	8
9	21	Clerical Supplies	Management Fee Income 5596693	20	103,786		270,000	5,007	9
10	22	Employee Benefits	Management Fee Income 5596693	20	538,870		270,000	25,997	10
11	23	Education/Conference	Management Fee Income 5596693	20	43,116		270,000	2,080	11
12	24	Travel	Management Fee Income 5596693	20	64,864		270,000	3,129	12
13	26	Insurance	Management Fee Income 5596693	20	1,591		270,000	77	13
14	30	Depreciation	Management Fee Income 5596693	20	32,015		270,000	1,544	14
15	32	Interest	Management Fee Income 5596693	20	2,051,940		270,000	98,991	15
16	34	Rent - Facility	Management Fee Income 5596693	20	156,067		270,000	7,529	16
17	35	Rent - Equipment	Management Fee Income 5596693	20	14,036		270,000	677	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 5,597,649	\$ 1,990,843		\$ 270,046	25

Facility Name & ID Number Provena McAuley Manor

0042879

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	91,080	\$ 57,717	1
2	22	Employee Benefits	Operating Expense	1,192,116	10	294,918		91,080	22,532	2
3	30	Depreciation	Operating Expense	1,192,116	10	820,363		91,080	62,677	3
4	19	Admin Consulting,Other	Operating Expense	1,192,116	10	2,423,574		91,080	185,166	4
5	17	Information Systems Salaries	Operating Expense	1,301,820	10	183,390	183,390	99,360	13,997	5
6	22	Information Systems Benefits	Operating Expense	1,301,820	10	71,595		99,360	5,464	6
7	6	Information Systems - Equip Main	Operating Expense	1,301,820	10	118,233		99,360	9,024	7
8	17	Admin Salaries	Direct Cost	1,192,116	10	507,799	507,799	91,080	38,797	8
9	22	Employee Benefits	Direct Cost	1,192,116	10	198,242		91,080	15,146	9
10	17	Information Systems Salaries	Direct Cost	1,301,820	10	341,798	341,798	99,360	26,087	10
11	22	Information Systems Benefits	Direct Cost	1,301,820	10	133,436		99,360	10,184	11
12	6	Information Systems - Equip Main	Direct Cost	1,301,820	10	311,444		99,360	23,771	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		\$ 470,562	25

Facility Name & ID Number Provena McAuley Manor

0042879

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		\$	\$		\$ 649,269	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				\$	\$		\$ 649,269	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1	2	3	4	5	6	7	8	9	10											
										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									95,007 10										
11										11										
12										12										
13										13										
14	TOTAL Non-Facility Related					\$	\$		\$	95,007 14										
15	TOTALS (line 9+line14)					\$	\$		\$	95,007 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.)

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 McAuley Manor COUNTY Kane

FACILITY IDPH LICENSE NUMBER 0042879

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 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. _____	_____	\$ _____	\$ _____
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 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 McAuley Manor

0042879 Report Period Beginning:

01/01/06 Ending:

12/31/06

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 51,000 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 2

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				\$	1
2					2
3	TOTALS			\$	3

Facility Name & ID Number Provena McAuley Manor

0042879

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 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	87		1986		\$ 4,218,962	\$ 168,758	25	\$ 168,758		\$ 3,459,549	4
5											5
6											6
7											7
8											8
Improvement Type**											
9	Various		1998		47,074	592	25	592		43,325	9
10	Various		1991		44,027	3,516	15	3,516		43,899	10
11	Various		1992		120,907	7,415	15	7,415		108,054	11
12	Various		1993		133,363	7,855	15	7,855		119,473	12
13	Various		1994		32,534	836	15	836		30,527	13
14	Various		1996		70,791	4,318	15	4,318		48,260	14
15	Various		1997		20,454	181	15	181		19,477	15
16	Various		1999		35,104	1,871	10	1,871		31,245	16
17	Various		2000		43,053	2,098	20	2,098		20,442	17
18	Various		2001		95,377	10,226	10	10,226		70,247	18
19	Various		2002		79,030	11,151	7	11,151		46,027	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 McAuley Manor

0042879

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: CARPET RELACEMENT- LOUNGE AND ADMINI	2003	\$ 10,515	\$ 2,103	5	\$ 2,103	\$	\$ 7,360	37
38	DESC: REPIPE CIRCULATING LINE AND INSTALL	2003	3,000	300	10	300		1,050	38
39	DESC: VACUUM PUMP	2003	1,847	369	5	369		1,293	39
40	DESC: FREON	2003	1,511	302	5	302		1,058	40
41	DESC: 50 GALLON ELECTRIC WATER HEATER	2003	4,758	476	10	476		1,665	41
42	DESC: PRIVATE CABLE TV SYSTEM	2003	22,812	2,281	10	2,281		7,984	42
43	DESC: PAINT ROOMS	2003	15,000	3,000	5	3,000		10,500	43
44	DESC: REFRIGERATION/COOLING CLEANING AND A	2003	3,355	671	5	671		2,349	44
45	DESC: PLEATED SHADES	2003	10,048	2,010	5	2,010		6,029	45
46	DESC: REPLACE 3 B&G HEATING PUMPS	2003	6,094	609	10	609		1,219	46
47	DESC: BORDER WALLCOVERING	2003	425	85	5	85		298	47
48	DESC: 2ND FLOOR NURSES STATION	2003	26,960	1,797	15	1,797		5,392	48
49	DESC: WALL SCONCES AND BORDER	2003	666	67	10	67		200	49
50	DESC: VOICE MAIL	2004	2,307	231	10	231		577	50
51	DESC: CCTV SYSTEM UPGRADE	2004	2,690	179	15	179		448	51
52	DESC: ALUMINUM DOORS	2004	4,500	225	20	225		563	52
53	DESC: COMPRESSOR REPAIR OF WALK IN FREEZER	2004	3,356	671	5	671		1,343	53
54	DESC: CALLXPRESS SOFTWARE	2004	3,590	718	5	718		1,795	54
55	DESC: ELEVATOR MOTOR	2004	2,900	145	20	145		363	55
56	DESC: ROOF REPAIR AND MAINTENANCE	2004	1,816	363	5	363		908	56
57	DESC: RESURFACE PAVING FOR PARKING LOT & R	2004	14,900	1,863	8	1,863		4,656	57
58	DESC: CONTROL RELACEMENT ON BOILER & CHILL	2004	47,000	4,700	10	4,700		11,750	58
59	DESC: ALUMINUM DOOR W/ SIDELITE FRAME	2004	1,900	190	10	190		475	59
60	DESC: REPLACE CONCRETE 8FT x 11FT IN ENTRY	2004	1,850	123	15	123		308	60
61	DESC: INSTALLED 30 YEAR SHINGLE ON THE CHA	2004	6,745	675	10	675		1,349	61
62	DESC: REPLACE PUMP W/ B&G PUMP	2004	3,728	373	10	373		746	62
63	DESC: DISHWASHER	2004	1,950	195	10	195		390	63
64	DESC: 100V DOOR HOLDERS & WIREMOLD LOW VOL	2004	1,117	223	5	223		447	64
65	DESC: EXTERIOR ELECTOHDRALIC DOOR AND INTE	2004	4,025	403	10	403		805	65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 5,152,040	\$ 244,165		\$ 244,165	\$	\$ 4,113,843	70

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

Facility Name & ID Number Provena McAuley Manor

0042879

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		\$ 5,152,040	\$ 244,165		\$ 244,165	\$	\$ 4,113,843	1
2	DESC: CONVENT SCREENS	2005	3,200	640	5	640			2
3	DESC: DRAIN PIPING AND REROUTE PIPING	2005	512	51	10	51			3
4	DESC: LENNOX HS29-018 CONDENSING UNIT & 2	2005	12,000	800	15	800			4
5	DESC: INSTALL CIRCUIT BREAKER PANEL & HVAC	2005	10,535	702	15	702			5
6	DESC: COADE ALERT - WANDERER SYSTEM	2005	3,435	344	10	344			6
7	DESC: INSTALL 1ST FLOOR NURSES STATION/PHY	2005	40,700	2,713	15	2,713			7
8	DESC: DRYWALL AND TAPING WORK	2005	1,630	163	10	163			8
9	DESC: FURNISH AND INSTALL SOFT STARTERS FO	2005	2,623	262	10	262			9
10	DESC: WANDERER SYSTEM	2005	3,583	358	10	358			10
11	DESC: KM SYSTEMS 2100 SERIES ELECTROHYDRAL	2005	4,031	403	10	403			11
12	DESC: REPLACE CONCRETE AT LOWER AND TOP PA	2005	16,390	1,093	15	1,093			12
13	DESC: IDPH REQ. REPAIRS	2005	23,370	2,337	10	2,337			13
14	DESC: REPAIR OF SEWER IN DISWASHING ROOM	2005	4,192	419	10	419			14
15	DESC: EXTERIOR METAL HANDRAILS AND ENAMEL	2005	1,585	159	10	159			15
16	DESC: FIRE PROTECTION SUPPRESSION SPRINKLER	2005	16,150	646	25	646			16
17	DESC: GENERAL MAINT. AND BASE FLASHING REP	2005	9,850	985	10	985			17
18	DESC: RENOVATION OF BATHROOMS	2005	31,579	2,105	15	2,105			18
19	DESC: CARPETING FOR HALL/CHAPEL HALL/ ADMI	2005	9,804	1,961	5	1,961			19
20	DESC: REPLACE CURB AND SIDEWALKS	2005	15,840	1,056	15	1,056			20
21	DESC: 3 RAIL FENCING	2005	3,691	246	15	246			21
22	DESC: REPLACEMENT OF PATIENT ROOM DOORS	2005	18,634	1,242	15	1,242			22
23	DESC: RENOVATION OF 7 BATHROOMS	2006	11,471	382	15	765	382		23
24	DESC: DOOR REPLACEMENT LOWER CORRIDOR,CONF	2006	5,350	178	15	357	178		24
25	DESC: ROOF REPAIRS	2006	8,950	448	10	895	448		25
26	DESC: KITCHEN / DINING ROOM	2006	4,906	245	10	491	245		26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,416,051	\$ 264,104		\$ 265,358	\$ 1,253	\$ 4,113,843	34

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

Facility Name & ID Number Provena McAuley Manor # 0042879 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	\$ 327,609	\$ 33,512	\$ 33,512	\$	10	\$ 95,088	71
72	Current Year Purchases	113,626	5,458	10,916	5,458	10	10,916	72
73	Fully Depreciated Assets	675,363					675,363	73
74	Home office allocation		64,221	64,221				74
75	TOTALS	\$ 1,116,598	\$ 103,191	\$ 108,649	\$ 5,458		\$ 781,367	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		1999 Ford Eldorado	1999	\$ 42,261	\$ 5,283	\$ 5,283	\$	8	\$ 39,620	76
77										77
78										78
79										79
80	TOTALS			\$ 42,261	\$ 5,283	\$ 5,283	\$		\$ 39,620	80

E. Summary of Care-Related Assets

	1	Reference	2	Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)		\$ 6,574,910	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 372,578	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 379,290	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$ 6,711	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 4,934,830	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				7,529			5
6					_____			6
7	TOTAL				\$ 7,529			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: \$ 34,823 Description: Nursing \$28,280, Dietary \$875, Plant Eng \$303, Pastoral Care \$140, Admin \$4,548, Home Office \$677

(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.

Facility Name & ID Number Provena McAuley Manor# 0042879

Report Period Beginning:

01/01/06

Ending:

12/31/06

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	\$	4,225	\$ 220,539	\$	4,225	\$ 220,539	1
2	Licensed Speech and Language Development Therapist	10a,3	hrs		563	29,406		563	29,406	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a,3	hrs		5,597	292,145		5,597	292,145	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				649,269		649,269	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			\$	10,385	\$ 542,090	\$ 649,269	10,385	\$ 1,191,359	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 McAuley Manor# 0042879Report 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	2	
		Operating	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	2	
		Operating	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)	\$ 73,502,582	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 84,761,685	\$	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	1,160,508	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 72,913,723	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	332,662	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)	\$ 588,859	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)	\$ 73,502,582	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Provena McAuley Manor# 0042879Report 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	\$ 4,859,155	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,859,155	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,670,166	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,670,166	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	12,064	13
14	Non-Patient Meals	13,338	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	108,610	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	24,242	20
21	Other Medical Services		21
22	Laundry	16,681	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 174,935	23
D. Non-Operating Revenue			
24	Contributions	59,955	24
25	Interest and Other Investment Income***	3,984	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 63,939	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Purchase Rebates</u>	186,303	28
28a	<u>Misc. Income</u>	101,431	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 287,734	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,055,929	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	984,322	31
32	Health Care	3,138,299	32
33	General Administration	1,590,839	33
B. Capital Expense			
34	Ownership	312,905	34
C. Ancillary Expense			
35	Special Cost Centers	649,269	35
36	Provider Participation Fee	47,633	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,723,267	40
41	Income before Income Taxes (line 30 minus line 40)**	332,662	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 332,662	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 McAuley Manor

0042879

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	1,832	2,080	\$ 83,236	\$ 40.02	1
2	Assistant Director of Nursing	1,776	2,080	56,190	27.01	2
3	Registered Nurses	16,377	17,174	619,285	36.06	3
4	Licensed Practical Nurses	6,615	7,160	179,420	25.06	4
5	CNAs & Orderlies	56,424	61,977	816,946	13.18	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,486	2,687	40,941	15.24	8
9	Activity Director	2,354	2,444	35,114	14.37	9
10	Activity Assistants	2,666	2,793	24,319	8.71	10
11	Social Service Workers	1,952	2,080	33,214	15.97	11
12	Dietician	1,494	1,560	35,836	22.97	12
13	Food Service Supervisor	1,514	1,619	22,272	13.76	13
14	Head Cook	3,679	3,870	38,703	10.00	14
15	Cook Helpers/Assistants	9,449	10,034	84,491	8.42	15
16	Dishwashers					16
17	Maintenance Workers	3,053	3,375	70,918	21.01	17
18	Housekeepers	17,387	19,343	180,999	9.36	18
19	Laundry	2,045	2,216	23,434	10.57	19
20	Administrator	1,888	2,123	91,909	43.29	20
21	Assistant Administrator	1,828	2,080	55,855	26.85	21
22	Other Administrative	6,630	7,080	96,573	13.64	22
23	Office Manager					23
24	Clerical	3,054	3,492	35,773	10.24	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>	1,844	2,088	33,365	15.98	33
34	TOTAL (lines 1 - 33)	146,347	159,355	\$ 2,658,793 *	\$ 16.68	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	96	\$ 6,997	1,3	35
36	Medical Director	\$1000/mo	12,000	9,3	36
37	Medical Records Consultant	16	920	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	45	2,595	11,3	44
45	Social Service Consultant	6	405	12,3	45
46	Other(specify)				46
47	<u>Podiatrist</u>	35	5,175	9,3	47
48					48
49	TOTAL (lines 35 - 48)	198	\$ 28,092		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	6,235	\$ 324,462	10,3	50
51	Licensed Practical Nurses	2,474	103,496	10,3	51
52	Certified Nurse Assistants/Aides	614	14,071	10,3	52
53	TOTAL (lines 50 - 52)	9,323	\$ 442,029		53

Facility Name & ID Number Provena McAuley Manor

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. 4222 - 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? 87
- (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. \$ 28,210 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. NA
- (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. \$ 47,633
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? Yes Indicate the amount. \$ 13,338
- (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.