

		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:** 0041871

**Facility Name:** Provena St Joseph Center

**Address:** 659 East Jefferson Street Freeport 61032  
 Number City Zip Code

**County:** Stephenson

**Telephone Number:** (815) 232-6181 **Fax #** (815) 232-6143

**HFS ID Number:** 371127787011

**Date of Initial License for Current Owners:** 07/01/96

**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
<b>IRS Exemption Code</b> <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.

<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) _____
	(Type or Print Name) <u>Michael R. Gordon</u>	
	(Title) <u>VP of Finance, CFO</u>	
<b>Paid Preparer</b>	(Signed) _____	(Date) _____
	(Print Name and Title) _____	
	(Firm Name & Address) _____	
	(Telephone) ( ) _____	Fax # ( ) _____
	<b>MAIL TO: BUREAU OF HEALTH FINANCE</b> <b>ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES</b> <b>201 S. Grand Avenue East</b> <b>Springfield, IL 62763-0001</b>	

**Phone # (217) 782-1630**

Facility Name & ID Number Provena St Joseph Center# 0041871 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>120</u>	Skilled (SNF)	<u>120</u>	<u>43,800</u>	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	<u>120</u>	TOTALS	<u>120</u>	<u>43,800</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>17,531</u>	<u>18,742</u>	<u>4,720</u>	<u>40,993</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>17,531</u>	<u>18,742</u>	<u>4,720</u>	<u>40,993</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.59%

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 - NoneF. Does the facility maintain a daily midnight census? Yes

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

YES  NO 

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES  NO 

I. On what date did you start providing long term care at this location?

Date started 7/1/1996

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

YES  Date 7/1/1996 NO 

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

YES  NO  If YES, enter number of beds certified 120 and days of care provided 4,230Medicare 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 St Joseph Center # 0041871 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	
	<b>A. General Services</b>											
1	Dietary	288,575	35,195	14,757	338,527		338,527		338,527			1
2	Food Purchase		169,559		169,559		169,559	(31,846)	137,713			2
3	Housekeeping	70,138	26,706	260	97,104		97,104		97,104			3
4	Laundry	40,058	2,025	124,673	166,756		166,756		166,756			4
5	Heat and Other Utilities			103,882	103,882		103,882	1,283	105,165			5
6	Maintenance	101,031	22,779	44,996	168,806		168,806	34,751	203,557			6
7	Other (specify):* <b>Pastoral Care</b>	21,898	2,275	17,744	41,917		41,917	(18,637)	23,280			7
8	<b>TOTAL General Services</b>	<b>521,700</b>	<b>258,539</b>	<b>306,312</b>	<b>1,086,551</b>		<b>1,086,551</b>	<b>(14,449)</b>	<b>1,072,102</b>			8
	<b>B. Health Care and Programs</b>											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	1,908,671	140,498	87,201	2,136,370		2,136,370		2,136,370			10
10a	Therapy			227,196	227,196		227,196		227,196			10a
11	Activities	83,182	933	3,659	87,774		87,774	1,479	89,253			11
12	Social Services	49,696	233	1,100	51,029		51,029		51,029			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	<b>TOTAL Health Care and Programs</b>	<b>2,041,549</b>	<b>141,664</b>	<b>331,156</b>	<b>2,514,369</b>		<b>2,514,369</b>	<b>1,479</b>	<b>2,515,848</b>			16
	<b>C. General Administration</b>											
17	Administrative	207,751	18,733	780,300	1,006,784		1,006,784	(418,149)	588,635			17
18	Directors Fees											18
19	Professional Services			9,459	9,459		9,459	229,720	239,179			19
20	Dues, Fees, Subscriptions & Promotions			34,847	34,847		34,847	(11,547)	23,300			20
21	Clerical & General Office Expenses			60,770	60,770		60,770	(167,157)	(106,387)			21
22	Employee Benefits & Payroll Taxes			729,579	729,579		729,579	111,960	841,539			22
23	Inservice Training & Education			10,918	10,918		10,918	4,467	15,385			23
24	Travel and Seminar			10,663	10,663		10,663	6,721	17,384			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			114,850	114,850		114,850	165	115,015			26
27	Other (specify):* <b>Bad Debt</b>			15,266	15,266		15,266	(15,266)				27
28	<b>TOTAL General Administration</b>	<b>207,751</b>	<b>18,733</b>	<b>1,766,652</b>	<b>1,993,136</b>		<b>1,993,136</b>	<b>(259,086)</b>	<b>1,734,050</b>			28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>2,771,000</b>	<b>418,936</b>	<b>2,404,120</b>	<b>5,594,056</b>		<b>5,594,056</b>	<b>(272,056)</b>	<b>5,322,000</b>			29

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

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

Facility Name & ID Number Provena St Joseph Center #0041871 Report Period Beginning: 01/01/06 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	
	<b>D. Ownership</b>											
30	Depreciation			212,332	212,332	212,332	87,517	299,849				30
31	Amortization of Pre-Op. & Org.											31
32	Interest						208,760	208,760				32
33	Real Estate Taxes			300,000	300,000	300,000		300,000				33
34	Rent-Facility & Grounds						16,171	16,171				34
35	Rent-Equipment & Vehicles			7,434	7,434	7,434	1,454	8,888				35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			519,766	519,766	519,766	313,902	833,668				37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			251,557	251,557	251,557		251,557				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			65,700	65,700	65,700		65,700				42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			317,257	317,257	317,257		317,257				44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,771,000	418,936	3,241,143	6,431,079	6,431,079	41,846	6,472,925				45

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

Facility Name & ID Number Provena St Joseph Center

# 0041871

Report Period Beginning: 01/01/06

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	(35,567)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	18,220	30		9
10	Interest and Other Investment Income	(3,851)	32		10
11	Discounts, Allowances, Rebates & Refunds	(177,911)	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	(15,266)	27		24
25	Fund Raising, Advertising and Promotional	(20,133)	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	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (234,508)		\$	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)	294,991		34
35	Other- Attach Schedule	(18,637)		35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 276,354		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ 41,846		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY					
48		49		50	51
					52

Provena St Joseph Center

ID# 0041871

Report Period Beginning: 01/01/06

Ending: 12/31/06

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Development Supplies	\$ (338)	7	1
2	Development Office Supplies	(779)	7	2
3	Development Other Supplies	(60)	7	3
4	Development Misc.	(17,460)	7	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(18,637)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Provena St Joseph Center

# 0041871

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)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(35,567)	3,721	0	0	0	0	0	0	0	0	0	(31,846)	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	1,283	0	0	0	0	0	0	0	0	0	1,283	5
6	Maintenance	0	253	34,498	0	0	0	0	0	0	0	0	34,751	6
7	Other (specify):*	(18,637)	0	0	0	0	0	0	0	0	0	0	(18,637)	7
8	<b>TOTAL General Services</b>	<b>(54,204)</b>	<b>5,257</b>	<b>34,498</b>	<b>0</b>	<b>(14,449)</b>	<b>8</b>							
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	1,479	0	0	0	0	0	0	0	0	0	1,479	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	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>1,479</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>1,479</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	(361,515)	(56,634)	0	0	0	0	0	0	0	0	(418,149)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	34,796	194,924	0	0	0	0	0	0	0	0	229,720	19
20	Fees, Subscriptions & Promotions	(20,133)	8,586	0	0	0	0	0	0	0	0	0	(11,547)	20
21	Clerical & General Office Expenses	(177,911)	10,754	0	0	0	0	0	0	0	0	0	(167,157)	21
22	Employee Benefits & Payroll Taxes	0	55,835	56,125	0	0	0	0	0	0	0	0	111,960	22
23	Inservice Training & Education	0	4,467	0	0	0	0	0	0	0	0	0	4,467	23
24	Travel and Seminar	0	6,721	0	0	0	0	0	0	0	0	0	6,721	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	165	0	0	0	0	0	0	0	0	0	165	26
27	Other (specify):*	(15,266)	0	0	0	0	0	0	0	0	0	0	(15,266)	27
28	<b>TOTAL General Administration</b>	<b>(213,310)</b>	<b>(240,191)</b>	<b>194,415</b>	<b>0</b>	<b>(259,086)</b>	<b>28</b>							
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(267,514)</b>	<b>(233,455)</b>	<b>228,913</b>	<b>0</b>	<b>(272,056)</b>	<b>29</b>							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Provena St Joseph Center

# 0041871 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	18,220	0	69,297	0	0	0	0	0	0	0	0	87,517	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,851)	0	212,611	0	0	0	0	0	0	0	0	208,760	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	16,171	0	0	0	0	0	0	0	0	16,171	34
35	Rent-Equipment & Vehicles	0	0	1,454	0	0	0	0	0	0	0	0	1,454	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>14,369</b>	<b>0</b>	<b>299,533</b>	<b>0</b>	<b>313,902</b>	<b>37</b>							
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(253,145)</b>	<b>(233,455)</b>	<b>528,446</b>	<b>0</b>	<b>41,846</b>	<b>45</b>							

Facility Name & ID Number Provena St Joseph Center

# 0041871

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 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)
1	V	2 Food	\$	Provena Senior Services	100.00%	\$ 3,721	\$ 3,721 1
2	V	5 Utilities		Provena Senior Services	100.00%	1,283	1,283 2
3	V	6 Maintenance - Other		Provena Senior Services	100.00%	253	253 3
4	V	11 Activities-Special Events		Provena Senior Services	100.00%	1,479	1,479 4
5	V	17 Admin - Misc. Other	579,900	Provena Senior Services	100.00%	12,104	(567,796) 5
6	V	17 Administrative Services		Provena Senior Services	100.00%	206,281	206,281 6
7	V	19 Professional Salaries		Provena Senior Services	100.00%	34,796	34,796 7
8	V	20 Dues,Subscriptions		Provena Senior Services	100.00%	8,586	8,586 8
9	V	21 Clerical Supplies		Provena Senior Services	100.00%	10,754	10,754 9
10	V	22 Employee Benefits		Provena Senior Services	100.00%	55,835	55,835 10
11	V	23 Education/Conference		Provena Senior Services	100.00%	4,467	4,467 11
12	V	24 Travel		Provena Senior Services	100.00%	6,721	6,721 12
13	V	26 Insurance		Provena Senior Services	100.00%	165	165 13
14	Total		\$ 579,900			\$ 346,445	\$ * (233,455) 14

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

Facility Name & ID Number Provena St Joseph Center# 0041871Report 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 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
		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%	\$ 3,317	\$ 3,317	15
16	V	32	Interest		Provena Senior Services	100.00%	212,611	212,611	16
17	V	34	Rent - Facility		Provena Senior Services	100.00%	16,171	16,171	17
18	V	35	Rent - Equipment		Provena Senior Services	100.00%	1,454	1,454	18
19	V	17	Admin Salaries	95,880	Provena Health Services	100.00%	60,759	(35,121)	19
20	V	22	Employee Benefits		Provena Health Services	100.00%	23,720	23,720	20
21	V	30	Depreciation		Provena Health Services	100.00%	65,980	65,980	21
22	V	19	Admin Consulting,Other		Provena Health Services	100.00%	194,924	194,924	22
23	V	17	Information Systems Salaries	104,520	Provena Health Services	100.00%	14,724	(89,796)	23
24	V	22	Information Systems Benefits		Provena Health Services	100.00%	5,748	5,748	24
25	V	6	Information Systems - Equip Maint		Provena Health Services	100.00%	9,493	9,493	25
26	V	17	Admin Salaries		Provena Health Services	100.00%	40,841	40,841	26
27	V	22	Employee Benefits		Provena Health Services	100.00%	15,944	15,944	27
28	V	17	Information Systems Salaries		Provena Health Services	100.00%	27,442	27,442	28
29	V	22	Information Systems Benefits		Provena Health Services	100.00%	10,713	10,713	29
30	V	6	Information Systems - Equip Maint		Provena Health Services	100.00%	25,005	25,005	30
31	V	39	Ancillary Services - Other	251,557	Provena Senior Services Pharmacy	100.00%	251,557		31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 451,957				\$ 980,403	\$ * 528,446	39

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

Facility Name &amp; ID Number

Provena St Joseph Center

#

0041871

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 St Joseph Center

# 0041871

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	\$	579,900	\$ 3,721	1
2	5	Utilities	Management Fee Income 5,596,693	20	12,383		579,900	1,283	2
3	6	Maintenance - Other	Management Fee Income 5,596,693	20	2,446		579,900	253	3
4	11	Activities-Special Events	Management Fee Income 5,596,693	20	14,275		579,900	1,479	4
5	17	Admin - Misc. Other	Management Fee Income 5,596,693	20	116,818		579,900	12,104	5
6	17	Administrative Salaries	Management Fee Income 5,596,693	20	1,990,843	1,990,843	579,900	206,281	6
7	19	Professional Services	Management Fee Income 5,596,693	20	335,820		579,900	34,796	7
8	20	Dues,Subscriptions	Management Fee Income 5,596,693	20	82,869		579,900	8,586	8
9	21	Clerical Supplies	Management Fee Income 5,596,693	20	103,786		579,900	10,754	9
10	22	Employee Benefits	Management Fee Income 5,596,693	20	538,870		579,900	55,835	10
11	23	Education/Conference	Management Fee Income 5,596,693	20	43,116		579,900	4,467	11
12	24	Travel	Management Fee Income 5,596,693	20	64,864		579,900	6,721	12
13	26	Insurance	Management Fee Income 5,596,693	20	1,591		579,900	165	13
14	30	Depreciation	Management Fee Income 5,596,693	20	32,015		579,900	3,317	14
15	32	Interest	Management Fee Income 5,596,693	20	2,051,940		579,900	212,611	15
16	34	Rent - Facility	Management Fee Income 5,596,693	20	156,067		579,900	16,171	16
17	35	Rent - Equipment	Management Fee Income 5,596,693	20	14,036		579,900	1,454	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 5,597,649	\$ 1,990,843		\$ 579,998	25

Facility Name & ID Number Provena St Joseph Center

# 0041871

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

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

1	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	95,880	\$ 60,759	1
2	22	Employee Benefits	Operating Expense	1,192,116	10	294,918		95,880	23,720	2
3	30	Depreciation	Operating Expense	1,192,116	10	820,363		95,880	65,980	3
4	19	Admin Consulting,Other	Operating Expense	1,192,116	10	2,423,574		95,880	194,924	4
5	17	Information Systems Salaries	Operating Expense	1,301,820	10	183,390	183,390	104,520	14,724	5
6	22	Information Systems Benefits	Operating Expense	1,301,820	10	71,595		104,520	5,748	6
7	6	Information Systems - Equip Main	Operating Expense	1,301,820	10	118,233		104,520	9,493	7
8	17	Admin Salaries	Direct Cost	1,192,116	10	507,799	507,799	95,880	40,841	8
9	22	Employee Benefits	Direct Cost	1,192,116	10	198,242		95,880	15,944	9
10	17	Information Systems Salaries	Direct Cost	1,301,820	10	341,798	341,798	104,520	27,442	10
11	22	Information Systems Benefits	Direct Cost	1,301,820	10	133,436		104,520	10,713	11
12	6	Information Systems - Equip Main	Direct Cost	1,301,820	10	311,444		104,520	25,005	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		\$ 495,293	25

Facility Name & ID Number Provena St Joseph Center

# 0041871 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		\$	\$		\$ 251,557	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				\$	\$		\$ 251,557	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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1										1										
2										2										
3										3										
4										4										
5										5										
<b>Working Capital</b>																				
6										6										
7										7										
8										8										
9	<b>TOTAL Facility Related</b>					\$	\$		\$	9										
<b>B. Non-Facility Related*</b>																				
10	<b>Provena Senior Services</b>									<b>208,760</b>	10									
11											11									
12											12									
13											13									
14	<b>TOTAL Non-Facility Related</b>					\$	\$		\$	<b>208,760</b>	14									
15	<b>TOTALS (line 9+line14)</b>					\$	\$		\$	<b>208,760</b>	15									

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

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

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

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2005 report.		<b>Important</b> , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	2
3. Under or (over) accrual (line 2 minus line 1).			\$	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)			\$ <b>300,000</b>	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>			\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>			\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$ <b>300,000</b>	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:				
2001	_____	8		
2002	_____	9		
2003	_____	10		
2004	_____	11		
2005	_____	12		
			<b>FOR BHF USE ONLY</b>	
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 St Joseph Center COUNTY Stephenson

FACILITY IDPH LICENSE NUMBER 0041871

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>To Be Determined</u>	<u></u>	\$ <u>300,000.00</u>	\$ <u>300,000.00</u>
2. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
3. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
4. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
5. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
6. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
<b>TOTALS</b>		\$ <u>300,000.00</u>	\$ <u>300,000.00</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 St Joseph Center

# 0041871 Report Period Beginning:

01/01/06 Ending:

12/31/06

**X. BUILDING AND GENERAL INFORMATION:**

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

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

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

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

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Nursing Home</u>		<u>1996</u>	<u>\$ 1,400,000</u>	1
2					2
3	<b>TOTALS</b>			<b>\$ 1,400,000</b>	3

Facility Name &amp; ID Number Provena St Joseph Center

# 0041871

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	120		1996	1994	\$ 2,500,000	\$ 62,500	40	\$ 62,500	\$	\$ 657,250	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	Various			1997	24,480	351	6	351		24,305	9
10	Various			1998	6,818	372	6	372		6,260	10
11	Various			1999	82,714	5,643	8	5,643		46,338	11
12	Various			2000	18,963	652	6	652		16,923	12
13	Various			2001	20,465	1,780	9	1,780		14,123	13
14	Various			2002	56,255	7,721	11	7,721		31,514	14
15											15
16	DESC: INSTALLATION OF AWNING			2003	2,950	295	10	295		1,033	16
17	DESC: INSTALLATION OF ELECTRIC BASEBOARD			2003	751	75	10	75		263	17
18	DESC: DUCTLESS SPLIT SYSTEM FOR O'NEILL			2003	11,700	780	15	780		2,730	18
19	DESC: DURO LASST ROOFING SYSTEM			2003			10				19
20	DESC: DURO-LAST ROOFING SYSTEM			2003	21,167	2,117	10	2,117		7,408	20
21	DESC: SAWCUTTING OF CONCRETE ROOFING			2003	300	60	5	60		210	21
22	DESC: VINYL POCKET REPLACEMENT			2003	2,343	469	5	469		1,640	22
23	DESC: A/C COMPRESSOR			2003	3,583	299	12	299		1,045	23
24	DESC: TRINITY HOUSE ROOF			2003	7,125	713	10	713		2,494	24
25	DESC: VINYL WINDOW REPLACEMENTS			2003	2,943	420	7	420		1,472	25
26	DESC: BOILER REPLACEMENT			2003	2,227	111	20	111		334	26
27	DESC: REBUILD HIP & RAFTERS ON FRONT POR			2003	5,598	560	10	560		1,959	27
28	DESC: REWIRE 2ND FLOOR OF O'NEILL HALL			2003	12,500	1,250	10	1,250		4,375	28
29	DESC: UPGRADE SERVICE FOR VILLA HOME			2003	3,250	325	10	325		1,138	29
30	DESC: ROOF REMOVAL			2003	4,000	400	10	400		1,400	30
31	DESC: CLF BATH AND SHOWER UPGRADE			2003	1,414	141	10	141		424	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 &amp; ID Number Provena St Joseph Center

# 0041871

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: BOILER REPAIR	2004	\$ 1,766	\$ 177	10	\$ 177	\$	\$ 442	37
38	DESC: BOILER REPAIR	2004	1,355	90	15	90		226	38
39	DESC: BOILER REPAIR	2004	1,015	102	10	102		254	39
40	DESC: PLASTER WORK IN LARGE CHAPEL	2004	5,150	515	10	515		1,288	40
41	DESC: PAINTING OF CHAPEL	2004	9,500	1,900	5	1,900		4,750	41
42	DESC: HEAT EXCHANGE FOR MAIN BOILER	2004	4,983	498	10	498		1,246	42
43	DESC: TELEPHONE SYSTEM	2004	5,303	530	10	530		1,326	43
44	DESC: CARPET AND LABOR	2004	7,030	1,406	5	1,406		3,515	44
45	DESC: ADD SPRINKLER TO STORAGE ROOM	2004	1,680	112	15	112		280	45
46	DESC: TOWER ROOF REPAIRS	2004	795	80	10	80		159	46
47									47
48	DESC: AUTOMATIC DOOR EQUIPMENT	2005	6,284	628	10	628		943	48
49	DESC: REPLACE FIREBOARD FOR ADC/CLF	2005	21,223	2,122	10	2,122		3,183	49
50	DESC: REPAIR UNDERGROUND STEAM LEAK	2005	6,710	671	10	671		1,007	50
51	DESC: INSTALLATION OF LARGE FLOOR DRAIN	2005	5,850	585	10	585		878	51
52	DESC: SEWER LINE	2005	18,420	921	20	921		1,382	52
53	DESC: REMOVAL OF WALL IN TV LOUNGE - CLF	2005	965	97	10	97		145	53
54	DESC: CARPETING	2005	563	113	5	113		169	54
55	DESC: 51" TOSHIBA HDTV MONITOR	2005	1,499	300	5	300		450	55
56	DESC: ASPHALT - CLF PROGRAM	2005	2,364	295	8	295		443	56
57	DESC: REPLACE FIREBOARD FOR ADC/CLF	2005	697	70	10	70		105	57
58	DESC: BOILER AT ONEILL HALL/REBUILD STEA	2005	30,950	1,548	20	1,548		2,321	58
59	DESC: WIRE KITCHEN RANGE HOOD INTO FIRE	2005	3,405	341	10	341		341	59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,929,053	\$ 100,133		\$ 100,133	\$	\$ 849,487	70

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

Facility Name & ID Number Provena St Joseph Center

# 0041871

Report Period Beginning:

01/01/06 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		\$ 2,929,053	\$ 100,133		\$ 100,133	\$	\$ 849,487	1
2	DESC: PATCH CEILINGS IN HALLWAY	2006	800	40	10	80	40	40	2
3	DESC: TRINITY HOUSE CARPETING	2006	1,741	174	5	348	174	174	3
4	DESC: TREE REMOVAL	2006	2,500	250	5	500	250	250	4
5	DESC: LANDSCAPING	2006	554	39	10	55	16	39	5
6	DESC: LANDSCAPING - REMOVAL OF 23 STUMPS	2006	800	40	10	80	40	40	6
7	DESC: SEWER LINE FROM HOUSE TO MAN HOLE	2006	116	19	3	39	19	19	7
8	DESC: REPAIR LOADING DOCK AREA	2006	3,664	229	8	458	229	229	8
9	DESC: FLOORING FOR KITCHENETTE, 2 NURSES	2006	2,595	260	5	519	260	260	9
10	DESC: RECOVER 2 L SHAPED AWNINGS	2006	2,380	119	10	238	119	119	10
11	DESC: SIDEWALK REPLACEMENT	2006	731	24	15	49	24	24	11
12	DESC: HIGH EFFICIENCY FURNACE	2006	7,125	238	15	475	238	238	12
13	DESC: FIRE SPRINKLER	2006	6,180	206	15	412	206	206	13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,958,239	\$ 101,771		\$ 103,386	\$ 1,615	\$ 851,125	34

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

Facility Name & ID Number Provena St Joseph Center # 0041871 Report Period Beginning: 01/01/06 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	\$ 815,517	\$ 84,082	\$ 85,368	\$ 1,286	9	\$ 527,716	71
72	Current Year Purchases	315,593	16,625	33,230	16,605	10	16,625	72
73	Fully Depreciated Assets	78,661					78,661	73
74	Home Office Allocation		69,297	69,297				74
75	TOTALS	\$ 1,209,771	\$ 170,004	\$ 187,894	\$ 17,891		\$ 623,002	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		1997 Dodge 2500	1997	\$ 24,090	\$	\$	\$	3	\$ 24,090	76
77		2001 Mercury Sable	2001	23,123				5	23,123	77
78		2003 Ford Turtle Top Van	2004	34,275	8,569	8,569		4	12,853	78
79										79
80	TOTALS			\$ 81,488	\$ 8,569	\$ 8,569	\$		\$ 60,066	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)		\$ 5,649,498	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 280,343	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 299,849	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$ 19,506	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 1,534,193	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				16,171			5
6					_____			6
7	TOTAL				\$ 16,171			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: \$ 27,519 Description: Nursing \$18,041, Plant Eng. \$490, Hskp \$100, Admin \$7,434, Home Office \$1,454

(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)	
<b>TOTAL TRAINED</b>	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the 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	\$	2,185	\$ 114,065	\$	2,185	\$ 114,065	1
2	Licensed Speech and Language Development Therapist	10a,3	hrs		89	4,621		89	4,621	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a,3	hrs		2,079	108,510		2,079	108,510	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				251,557		251,557	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			\$	4,353	\$ 227,196	\$ 251,557	4,353	\$ 478,753	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 St Joseph Center# 0041871Report 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*	
	<b>A. Current Assets</b>			
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	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 20,311,169	\$	10
	<b>B. Long-Term Assets</b>			
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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 64,450,517	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 84,761,686	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
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
	<b>Other Current Liabilities(specify):</b>			
36	<u>Due to Related Party</u>	595,505		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 9,045,089	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	1,289,822		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	276,292		42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>Conditional Asset Retirement</u>	647,900		43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 2,214,014	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 11,259,103	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 73,502,583	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 84,761,686	\$	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	1,380,355	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 73,133,570	6
	<b>A. Additions (deductions):</b>		
7	NET Income (Loss) (from page 19, line 43)	112,816	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)	\$ 369,013	17
	<b>B. Transfers (Itemize):</b>		
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)	\$ 73,502,583	24 *

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

Facility Name & ID Number Provena St Joseph Center# 0041871Report 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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 5,393,223	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 5,393,223	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	594,505	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 594,505	8
<b>C. Other Operating Revenue</b>			
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	35,567	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	6,610	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 42,177	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	323,651	24
25	Interest and Other Investment Income***	3,851	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 327,502	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Purchase Rebates</u>	177,911	28
28a	<u>Misc. Income</u>	8,577	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 186,488	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 6,543,895	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,086,551	31
32	Health Care	2,514,370	32
33	General Administration	1,993,135	33
<b>B. Capital Expense</b>			
34	Ownership	519,766	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	251,557	35
36	Provider Participation Fee	65,700	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 6,431,079	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	112,816	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 112,816	43

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

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

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

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

Facility Name & ID Number Provena St Joseph Center

# 0041871

Report Period Beginning:

01/01/06

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	1,784	2,080	\$ 72,071	\$ 34.65	1
2	Assistant Director of Nursing	1,823	2,023	50,187	24.81	2
3	Registered Nurses	9,122	9,840	220,508	22.41	3
4	Licensed Practical Nurses	29,419	31,767	598,122	18.83	4
5	CNAs & Orderlies	79,987	86,494	903,525	10.45	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,481	5,853	64,258	10.98	8
9	Activity Director	1,844	2,080	28,672	13.78	9
10	Activity Assistants	5,836	6,358	54,510	8.57	10
11	Social Service Workers	3,486	4,063	49,696	12.23	11
12	Dietician	1,848	2,080	43,647	20.98	12
13	Food Service Supervisor	2,234	2,417	28,628	11.84	13
14	Head Cook	6,161	6,565	57,874	8.82	14
15	Cook Helpers/Assistants	20,577	21,951	158,426	7.22	15
16	Dishwashers					16
17	Maintenance Workers	7,168	7,670	101,031	13.17	17
18	Housekeepers	8,337	8,963	70,138	7.83	18
19	Laundry	4,689	5,228	40,058	7.66	19
20	Administrator	1,724	2,080	90,526	43.52	20
21	Assistant Administrator					21
22	Other Administrative	3,220	3,522	45,798	13.00	22
23	Office Manager					23
24	Clerical	5,890	6,723	71,427	10.62	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)	1,836	2,000	21,898	10.95	33
34	TOTAL (lines 1 - 33)	202,466	219,757	\$ 2,771,000 *	\$ 12.61	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	219	\$ 14,480	1,3	35
36	Medical Director	\$1000/mo	12,000	9,3	36
37	Medical Records Consultant	8	460	10,3	37
38	Nurse Consultant	17	1,545	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	9	561	11,3	44
45	Social Service Consultant	23	1,350	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	276	\$ 30,396		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	282	\$ 11,072	10,3	50
51	Licensed Practical Nurses	1,007	36,489	10,3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	1,289	\$ 47,561		53





**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. 5135 Life Service Network
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? Yes If YES, what is the capacity? 120
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 7 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 25,308 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. \$ 65,700  
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. \$ 35,567
- (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.