

		FOR BHF USE				

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2007
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2007)

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 License ID Number: 0041046

Facility Name: Provena Cor Mariae Center

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

County: Winnebago

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

HFS ID Number: 371127787013

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

Type of Ownership:

<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code <u>501 C3</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/07 to 12/31/07 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

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

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

Facility Name & ID Number Provena Cor Mariae Center

0041046 Report Period Beginning: 01/01/07 Ending: 12/31/07

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>73</u>	Skilled (SNF)	<u>73</u>	<u>26,645</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	<u>89</u>	Sheltered Care (SC)	<u>89</u>	<u>32,485</u>	5
6		ICF/DD 16 or Less			6
7	<u>162</u>	TOTALS	<u>162</u>	<u>59,130</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>3,599</u>	<u>12,890</u>	<u>8,964</u>	<u>25,453</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC		<u>28,750</u>		<u>28,750</u>	12
13	DD 16 OR LESS					13
14	TOTALS	<u>3,599</u>	<u>41,640</u>	<u>8,964</u>	<u>54,203</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.67%

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

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

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

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

N/A - None

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

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

YES NO

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

YES NO

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

Date started 6/5/1995

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

YES Date 06/05/1995 NO

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

YES NO If YES, enter number of beds certified 73 and days of care provided 8,964

Medicare Intermediary Administar Federal

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/07 Fiscal Year: 12/31/07

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

Facility Name & ID Number Provena Cor Mariae Center # 0041046 Report Period Beginning: 01/01/07 Ending: 12/31/07

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 BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	425,387	94,689	17,353	537,429		537,429	537,429			1
2	Food Purchase		370,669		370,669		370,669	4,204	374,873		2
3	Housekeeping	157,027	29,298	2,500	188,825		188,825		188,825		3
4	Laundry	55,695	10,758		66,453		66,453		66,453		4
5	Heat and Other Utilities			316,209	316,209		316,209	1,926	318,135		5
6	Maintenance	127,372	58,177	93,392	278,941		278,941	22,399	301,340		6
7	Other (specify):* Pastoral Care	20,678	3,331	11,129	35,138		35,138		35,138		7
8	TOTAL General Services	786,159	566,922	440,583	1,793,664		1,793,664	28,529	1,822,193		8
	B. Health Care and Programs										
9	Medical Director			19,250	19,250		19,250		19,250		9
10	Nursing and Medical Records	2,424,938	220,239	290,933	2,936,110		2,936,110		2,936,110		10
10a	Therapy			967,731	967,731		967,731		967,731		10a
11	Activities	263,858	16,308	12,664	292,830		292,830	601	293,431		11
12	Social Services	89,861	900	174	90,935		90,935		90,935		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,778,657	237,447	1,290,752	4,306,856		4,306,856	601	4,307,457		16
	C. General Administration										
17	Administrative	347,762	52,769	911,040	1,311,571		1,311,571	(275,505)	1,036,066		17
18	Directors Fees										18
19	Professional Services			15,774	15,774		15,774	164,800	180,574		19
20	Dues, Fees, Subscriptions & Promotions			75,441	75,441		75,441	(38,391)	37,050		20
21	Clerical & General Office Expenses			37,317	37,317		37,317	10,474	47,791		21
22	Employee Benefits & Payroll Taxes			860,567	860,567		860,567	104,199	964,766		22
23	Inservice Training & Education			12,158	12,158		12,158	4,998	17,156		23
24	Travel and Seminar			15,575	15,575		15,575	7,139	22,714		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			115,200	115,200		115,200	1,318	116,518		26
27	Other (specify):* Bad Debt			136,810	136,810		136,810	(136,810)			27
28	TOTAL General Administration	347,762	52,769	2,179,882	2,580,413		2,580,413	(157,778)	2,422,635		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,912,578	857,138	3,911,217	8,680,933		8,680,933	(128,648)	8,552,285		29

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

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

Facility Name & ID Number Provena Cor Mariae Center

#0041046

Report Period Beginning:

01/01/07

Ending:

12/31/07

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			366,870	366,870	366,870	121,459	488,329				30
31	Amortization of Pre-Op. & Org.											31
32	Interest						198,687	198,687				32
33	Real Estate Taxes			600	600	600		600				33
34	Rent-Facility & Grounds						17,130	17,130				34
35	Rent-Equipment & Vehicles			11,260	11,260	11,260	2,330	13,590				35
36	Other (specify):*											36
37	TOTAL Ownership			378,730	378,730	378,730	339,606	718,336				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			616,199	616,199	616,199	(253,183)	363,016				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			39,888	39,888	39,888		39,888				42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			656,087	656,087	656,087	(253,183)	402,904				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,912,578	857,138	4,946,034	9,715,750	9,715,750	(42,225)	9,673,525				45

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

Facility Name & ID Number Provena Cor Mariae Center

0041046

Report Period Beginning: 01/01/07

Ending: 12/31/07

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	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	16,337	30		9
10	Interest and Other Investment Income	(11,698)	32		10
11	Discounts, Allowances, Rebates & Refunds	(253,183)	39		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	(136,810)	27		24
25	Fund Raising, Advertising and Promotional	(47,969)	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)	\$ (433,323)		\$	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)	391,098		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 391,098		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (42,225)		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					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY					
48		49		50	
				51	
					52

Provena Cor Mariae Center

ID# 0041046

Report Period Beginning: 01/01/07

Ending: 12/31/07

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
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			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	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Provena Cor Mariae Center

0041046

Report Period Beginning:

01/01/07

Ending:

12/31/07

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	4,204	0	0	0	0	0	0	0	0	0	4,204	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	1,926	0	0	0	0	0	0	0	0	0	1,926	5
6	Maintenance	0	506	21,893	0	0	0	0	0	0	0	0	22,399	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	6,636	21,893	0	0	0	0	0	0	0	0	28,529	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	601	0	0	0	0	0	0	0	0	0	601	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	601	0	0	0	0	0	0	0	0	0	601	16
	C. General Administration													
17	Administrative	0	(412,222)	136,717	0	0	0	0	0	0	0	0	(275,505)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	69,426	95,374	0	0	0	0	0	0	0	0	164,800	19
20	Fees, Subscriptions & Promotions	(47,969)	9,578	0	0	0	0	0	0	0	0	0	(38,391)	20
21	Clerical & General Office Expenses	0	10,474	0	0	0	0	0	0	0	0	0	10,474	21
22	Employee Benefits & Payroll Taxes	0	55,756	48,443	0	0	0	0	0	0	0	0	104,199	22
23	Inservice Training & Education	0	4,998	0	0	0	0	0	0	0	0	0	4,998	23
24	Travel and Seminar	0	7,139	0	0	0	0	0	0	0	0	0	7,139	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	1,318	0	0	0	0	0	0	0	0	0	1,318	26
27	Other (specify):*	(136,810)	0	0	0	0	0	0	0	0	0	0	(136,810)	27
28	TOTAL General Administration	(184,779)	(253,533)	280,534	0	0	0	0	0	0	0	0	(157,778)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(184,779)	(246,296)	302,427	0	0	0	0	0	0	0	0	(128,648)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Provena Cor Mariae Center

0041046

Report Period Beginning:

01/01/07 Ending:

12/31/07

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	16,337	0	105,122	0	0	0	0	0	0	0	0	121,459	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(11,698)	0	210,385	0	0	0	0	0	0	0	0	198,687	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	17,130	0	0	0	0	0	0	0	0	17,130	34
35	Rent-Equipment & Vehicles	0	0	2,330	0	0	0	0	0	0	0	0	2,330	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	4,639	0	334,967	0	339,606	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	(253,183)	0	0	0	0	0	0	0	0	0	0	(253,183)	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	(253,183)	0	0	0	0	0	0	0	0	0	0	(253,183)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(433,323)	(246,296)	637,394	0	(42,225)	45							

Facility Name & ID Number Provena Cor Mariae Center

0041046

Report Period Beginning:

01/01/07

Ending:

12/31/07

VII. RELATED PARTIES

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

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	2 Food	\$	Provena Senior Services	100.00%	\$ 4,204	\$ 4,204 1
2	V	5 Utilities		Provena Senior Services	100.00%	1,926	1,926 2
3	V	6 Maintenance - Other		Provena Senior Services	100.00%	506	506 3
4	V	11 Activities-Special Events		Provena Senior Services	100.00%	601	601 4
5	V	17 Admin - Misc. Other	631,080	Provena Senior Services	100.00%	12,587	(618,493) 5
6	V	17 Administrative Services		Provena Senior Services	100.00%	206,271	206,271 6
7	V	19 Professional Salaries		Provena Senior Services	100.00%	69,426	69,426 7
8	V	20 Dues,Subscriptions		Provena Senior Services	100.00%	9,578	9,578 8
9	V	21 Clerical Supplies		Provena Senior Services	100.00%	10,474	10,474 9
10	V	22 Employee Benefits		Provena Senior Services	100.00%	55,756	55,756 10
11	V	23 Education/Conference		Provena Senior Services	100.00%	4,998	4,998 11
12	V	24 Travel		Provena Senior Services	100.00%	7,139	7,139 12
13	V	26 Insurance		Provena Senior Services	100.00%	1,318	1,318 13
14	Total		\$ 631,080			\$ 384,784	\$ * (246,296) 14

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

Facility Name & ID Number Provena Cor Mariae Center # 0041046 Report Period Beginning: 01/01/07 Ending: 12/31/07

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	30 Depreciation	\$	Provena Senior Services	100.00%	\$ 3,719	\$ 3,719	15
16	V	32 Interest		Provena Senior Services	100.00%	210,385	210,385	16
17	V	34 Rent - Facility		Provena Senior Services	100.00%	17,130	17,130	17
18	V	35 Rent - Equipment		Provena Senior Services	100.00%	2,330	2,330	18
19	V	17 Admin Salaries	115,560	Provena Health Services	100.00%	92,797	(22,763)	19
20	V	22 Employee Benefits		Provena Health Services	100.00%	21,842	21,842	20
21	V	30 Depreciation		Provena Health Services	100.00%	101,403	101,403	21
22	V	19 Admin Consulting, Other		Provena Health Services	100.00%	95,374	95,374	22
23	V	17 Information Systems Salaries	164,400	Provena Health Services	100.00%	31,634	(132,766)	23
24	V	22 Information Systems Benefits		Provena Health Services	100.00%	7,254	7,254	24
25	V	17 Information Systems - Other		Provena Health Services	100.00%	210,049	210,049	25
26	V	17 Admin Salaries		Provena Health Services	100.00%	44,165	44,165	26
27	V	22 Employee Benefits		Provena Health Services	100.00%	10,395	10,395	27
28	V	17 Information Systems Salaries		Provena Health Services	100.00%	38,032	38,032	28
29	V	22 Information Systems Benefits		Provena Health Services	100.00%	8,952	8,952	29
30	V	6 Information Systems - Equip Maint		Provena Health Services	100.00%	21,893	21,893	30
31	V	39 Ancillary Services - Other	616,199	Provena Senior Services Pharmacy	100.00%	616,199		31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 896,159			\$ 1,533,553	\$ * 637,394	39

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

Facility Name & ID Number

Provena Cor Mariae Center

#

0041046

Report Period Beginning:

01/01/07

Ending:

12/31/07

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Provena Cor Mariae Center

0041046

Report Period Beginning: 01/01/07

Ending: 12/31/07

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 6,620,619	19	\$ 44,100	\$	631,080	\$ 4,204	1
2	5	Utilities	Management Fee Income 6,620,619	19	20,208		631,080	1,926	2
3	6	Maintenance - Other	Management Fee Income 6,620,619	19	5,313		631,080	506	3
4	11	Activities-Special Events	Management Fee Income 6,620,619	19	6,306		631,080	601	4
5	17	Admin - Misc. Other	Management Fee Income 6,620,619	19	132,045		631,080	12,587	5
6	17	Administrative Salaries	Management Fee Income 6,620,619	19	2,163,976	2,163,976	631,080	206,271	6
7	19	Professional Services	Management Fee Income 6,620,619	19	728,345		631,080	69,426	7
8	20	Dues,Subscriptions	Management Fee Income 6,620,619	19	100,486		631,080	9,578	8
9	21	Clerical Supplies	Management Fee Income 6,620,619	19	109,877		631,080	10,474	9
10	22	Employee Benefits	Management Fee Income 6,620,619	19	584,930		631,080	55,756	10
11	23	Education/Conference	Management Fee Income 6,620,619	19	52,430		631,080	4,998	11
12	24	Travel	Management Fee Income 6,620,619	19	74,891		631,080	7,139	12
13	26	Insurance	Management Fee Income 6,620,619	19	13,824		631,080	1,318	13
14	30	Depreciation	Management Fee Income 6,620,619	19	39,013		631,080	3,719	14
15	32	Interest	Management Fee Income 6,620,619	19	2,207,136		631,080	210,385	15
16	34	Rent - Facility	Management Fee Income 6,620,619	19	179,713		631,080	17,130	16
17	35	Rent - Equipment	Management Fee Income 6,620,619	19	24,448		631,080	2,330	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 6,487,041	\$ 2,163,976		\$ 618,348	25

Facility Name & ID Number Provena Cor Mariae Center

0041046

Report Period Beginning:

01/01/07

Ending: 12/31/07

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	1,239,804	10	\$ 995,585	\$ 995,585	115,560	\$ 92,797	1
2	22	Employee Benefits	Operating Expense	1,239,804	10	234,337		115,560	21,842	2
3	30	Depreciation	Operating Expense	1,239,804	10	1,087,913		115,560	101,403	3
4	19	Admin Consulting,Other	Operating Expense	1,239,804	10	1,023,231		115,560	95,374	4
5	17	Information Systems Salaries	Operating Expense	1,759,764	10	338,615	338,615	164,400	31,634	5
6	22	Information Systems Benefits	Operating Expense	1,759,764	10	77,649		164,400	7,254	6
7	17	Information Systems - Other	Operating Expense	1,759,764	10	2,248,393		164,400	210,049	7
8	17	Admin Salaries	Direct Cost	1,239,804	10	473,834	473,834	115,560	44,165	8
9	22	Employee Benefits	Direct Cost	1,239,804	10	111,529		115,560	10,395	9
10	17	Information Systems Salaries	Direct Cost	1,759,764	10	407,099	407,099	164,400	38,032	10
11	22	Information Systems Benefits	Direct Cost	1,759,764	10	95,822		164,400	8,952	11
12	6	Information Systems - Equip Main	Direct Cost	1,759,764	10	234,347		164,400	21,893	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					\$ 7,328,354	\$ 2,215,133		\$ 683,790	25

Facility Name & ID Number Provena Cor Mariae Center

0041046

Report Period Beginning: 01/01/07

Ending: 12/31/07

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		\$	\$		616,199	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				\$	\$		616,199	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	Name of Lender	2		3	4	5	6		8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required				Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
	A. Directly Facility Related																
	Long-Term																
1	Home Office Allocation						\$	\$			\$ 210,385	1					
2												2					
3												3					
4												4					
5												5					
	Working Capital																
6												6					
7												7					
8												8					
9	TOTAL Facility Related						\$	\$			\$ 210,385	9					
	B. Non-Facility Related*																
10												10					
11												11					
12												12					
13												13					
14	TOTAL Non-Facility Related						\$	\$			\$	14					
15	TOTALS (line 9+line14)						\$	\$			\$ 210,385	15					

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

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

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

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

B. Real Estate Taxes

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>			
1. Real Estate Tax accrual used on 2006 report.		\$ 1,847	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$ 1,106	2
3. Under or (over) accrual (line 2 minus line 1).		\$ (741)	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 1,341	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 600	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2002	8	
	2003	974	9
	2004	1,038	10
	2005	1,086	11
	2006	1,106	12
	FOR BHF USE ONLY		
	13	FROM R. E. TAX STATEMENT FOR 2006 \$	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:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

2006 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Provena Cor Mariae Center COUNTY Winnebago

FACILITY IDPH LICENSE NUMBER 0041046

CONTACT PERSON REGARDING THIS REPORT Lynda Olinski

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2006 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 2006.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>153B004C 12-09-104-035</u>	<u>Comm SE Cor LT Imperial O</u>	\$ <u>1,105.52</u>	\$ <u>1,105.52</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u>1,105.52</u>	\$ <u>1,105.52</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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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

Facility Name & ID Number Provena Cor Mariae Center

0041046 Report Period Beginning:

01/01/07 Ending:

12/31/07

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 115,889 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 5

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

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

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

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

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

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number Provena Cor Mariae Center

0041046

Report Period Beginning:

01/01/07

Ending:

12/31/07

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	89		1995	1964	\$ 1,035,000	\$ 33,333	30	\$ 33,333		\$ 451,667	4
5	63			1997	2,508,246	62,711	40	62,711		642,593	5
6	10			2005	955,153	38,384	25	38,384		94,104	6
7											7
8											8
Improvement Type**											
9	Various			1995	171,813	8,616	20	8,616		103,451	9
10	Various			1996	374,066	18,542	15	18,542		227,058	10
11	Various			1997	252,744	10,899	15	10,899		166,677	11
12	Various			1998	174,397	5,239	13	5,239		66,994	12
13	Various			1999	10,976	45	6	45		10,909	13
14	Various			2000	39,900	1,176	6	1,176		36,960	14
15	Various			2001	48,414	3,380	9	3,380		28,236	15
16	Various			2002	118,018	9,909	10	9,909		55,616	16
17	Various			2003	128,140	21,935	10	21,935		89,551	17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Provena Cor Mariae Center

0041046

Report Period Beginning:

01/01/07

Ending:

12/31/07

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	ROOF REPLACEMENT	2004	\$ 38,000	\$ 3,800	10	\$ 3,800	\$	\$ 15,200	37
38	TOSHIBA CTX670 TELEPHONE	2004	33,116	3,312	10	3,312		11,591	38
39	SEAL & STRIPING OF PARKI	2004	7,008	1,402	5	1,402		4,906	39
40	WATER MAIN REPAIR	2004	6,819	455	15	455		1,591	40
41	CALL LIGHT ITMING SYSTEM	2004	4,208	421	10	421		1,473	41
42	FRENCH DOORS	2004	4,000	267	15	267		933	42
43	PLAN BIDDING AND NEGOTIA	2004	3,187	637	5	637		2,231	43
44	REPAIR WATERMAIN	2004	2,712	181	15	181		633	44
45	SAW AND PATCH	2004	2,494	499	5	499		1,746	45
46	REPAIR OUTSIDE LIGHTS	2004	2,369	158	15	158		632	46
47	EXTRACTION OF WATER - WA	2004	1,040	208	5	208		728	47
48	UPGRADE KIT FOR SURFACE	2004	733	147	5	147		513	48
49	DRAFTING OF DESIGN DRAWI	2004	610	122	5	122		427	49
50									50
51									51
52									52
53	REROOF MAINTENANCE SHOP	2005	21,947	2,195	10	2,195		6,584	53
54	TEKNOFLOR#73803 SHEET VI	2005	8,780	878	10	878		2,195	54
55	LANDSCAPING	2005	5,950	595	10	595		1,488	55
56	RELOCATION OF UNDERGROUN	2005	5,736	382	15	382		956	56
57	PARTS/LABOR TO REPLACE W	2005	5,730	573	10	573		1,433	57
58	EXTERNAL SIGNAGE	2005	3,000	300	10	300		750	58
59	TEKNOFLOR IN SKILLED NUR	2005	2,170	310	7	310		775	59
60	SIGNAGE	2005	1,914	191	10	191		479	60
61	MVP WATER SOFTENER	2005	1,658	166	10	166		497	61
62	INSTALL BURN THROW DOOR	2005	818	82	10	82		245	62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 5,980,865	\$ 231,447		\$ 231,447	\$	\$ 2,031,820	70

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

Facility Name & ID Number Provena Cor Mariae Center

0041046

Report Period Beginning:

01/01/07

Ending:

12/31/07

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		\$ 5,980,865	\$ 231,447		\$ 231,447	\$	\$ 2,031,820	1
2	PATIO ROOF /FRONT ENTRAN	2006	42,366	4,237		4,237		6,355	2
3	FENCING INSTALLATION	2006	35,687	2,974		2,974		4,461	3
4	COOLING TOWER REPLACEMEN	2006	33,800	2,253		2,253		3,380	4
5	WATERMAIN REPAIR	2006	3,512	351		351		702	5
6									6
7	SHELTERED CARE SHOWER	2007	23,500	1,567		3,133	1,567	1,567	7
8	BATHROOM REMODEL	2007	14,804	493		987	493	493	8
9	CARPET REPLACEMENT FOR A	2007	14,500	1,450		2,900	1,450	1,450	9
10	REPAIRS TO FIRE PUMP SYS	2007	4,571	327		653	327	327	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	TOTAL (lines 1 thru 33)		\$ 6,153,606	\$ 245,099		\$ 248,936	\$ 3,837	\$ 2,050,555	34

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

Facility Name & ID Number Provena Cor Mariae Center # 0041046 Report Period Beginning: 01/01/07 Ending: 12/31/07

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,422,289	\$ 104,080	\$ 104,080	\$	10	\$ 658,420	71
72	Current Year Purchases	178,840	13,441	26,882	13,441	10	13,441	72
73	Fully Depreciated Assets	294,029				6	294,153	73
74	Home Office Allocation		105,122	105,122				74
75	TOTALS	\$ 1,895,158	\$ 222,643	\$ 236,084	\$ 13,441		\$ 966,014	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Plant Engineering	2000 Ford Eldorado	2000	\$ 42,500	\$ 4,250	\$ 4,250	\$	10	\$ 31,875	76
77	Plant Engineering	1991 Chevy Pickup	1995	14,000				5	14,000	77
78		Non Care Portion		(15,062)		(941)	(941)			78
79										79
80	TOTALS			\$ 41,438	\$ 4,250	\$ 3,309	\$ (941)		\$ 45,875	80

E. Summary of Care-Related Assets

	1	Reference	2	Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)		\$ 8,761,096	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 471,992	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 488,329	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$ 16,337	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 3,062,444	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ _____			3
4	Additions				_____			4
5	Home Office Allocation				17,130			5
6					_____			6
7	TOTAL				\$ 17,130			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.	_____ /2008	\$ _____
13.	_____ /2009	\$ _____
14.	_____ /2010	\$ _____

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: \$ 97,279 Description: Nursing \$81851, Activities \$189, Dietary \$288, Plant Eng. \$1361, Admin \$11260, Home Office \$2330
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$ _____	\$ _____	17
18			_____	_____	18
19			_____	_____	19
20			_____	_____	20
21	TOTAL		\$ _____	\$ _____	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a, 3	hrs	\$	8,325	\$ 449,542	\$	8,325	\$ 449,542	1
2	Licensed Speech and Language Development Therapist	10a, 3	hrs		891	48,092		891	48,092	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a, 3	hrs		8,706	470,097		8,706	470,097	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39, 3	# of prescrpts				616,199		616,199	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			\$	17,921	\$ 967,731	\$ 616,199	17,921	\$ 1,583,930	14

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

Facility Name & ID Number Provena Cor Mariae Center# 0041046Report Period Beginning: 01/01/07

Ending:

12/31/07

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/07

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 8,785,520	\$	1
2	Cash-Patient Deposits	113,303		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	11,176,143		3
4	Supply Inventory (priced at)	533,002		4
5	Short-Term Investments			5
6	Prepaid Insurance	16,312		6
7	Other Prepaid Expenses	134,911		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 20,759,191	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	7,331,517		12
13	Land	6,751,685		13
14	Buildings, at Historical Cost	83,408,867		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	18,112,162		16
17	Accumulated Depreciation (book methods)	(49,944,144)		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>	120,120		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 65,780,207	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 86,539,398	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 4,826,767	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,861,673		28
29	Short-Term Notes Payable	42,163		29
30	Accrued Salaries Payable	2,756,052		30
31	Accrued Taxes Payable (excluding real estate taxes)	80,845		31
32	Accrued Real Estate Taxes(Sch.IX-B)	823,060		32
33	Accrued Interest Payable	41,064		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Due to Related Party</u>	817,281		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 11,248,905	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,247,620		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	338,908		42
	Other Long-Term Liabilities(specify):			
43	<u>Conditional Asset Retirement</u>	450,209		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,036,737	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 13,285,642	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 73,253,756	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 86,539,398	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 73,502,583	1
2	Restatements (describe):		2
3	Transfer to Affiliates	(2,361,850)	3
4	Adj. To reconcile consolidated equity & consolidated income	1,959,850	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 73,100,583	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	269,845	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock	(333,474)	9
10	Stock Options Exercised		10
11	Contributions and Grants	417,345	11
12	Expenditures for Specific Purposes	(200,543)	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)	\$ 153,173	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)	\$ 73,253,756	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Provena Cor Mariae Center# 0041046Report Period Beginning: 01/01/07Ending: 12/31/07**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	\$ 7,495,997	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,495,997	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,491,402	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,491,402	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	592,272	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	1,839	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 594,111	23
D. Non-Operating Revenue			
24	Contributions	21,563	24
25	Interest and Other Investment Income***	11,698	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 33,261	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Purchase Rebates</u>	253,183	28
28a	<u>Misc. Income</u>	118,667	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 371,850	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,986,621	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,794,264	31
32	Health Care	4,306,856	32
33	General Administration	2,580,413	33
B. Capital Expense			
34	Ownership	378,130	34
C. Ancillary Expense			
35	Special Cost Centers	616,199	35
36	Provider Participation Fee	39,888	36
D. Other Expenses (specify):			
37	<u>Loss on SOFA</u>	1,026	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,716,776	40
41	Income before Income Taxes (line 30 minus line 40)**	269,845	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 269,845	43

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

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

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

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

Facility Name & ID Number Provena Cor Mariae Center

0041046

Report Period Beginning:

01/01/07

Ending:

12/31/07

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	1,944	2,008	\$ 86,653	\$ 43.15	1
2	Assistant Director of Nursing	227	267	7,894	29.57	2
3	Registered Nurses	21,010	22,966	683,962	29.78	3
4	Licensed Practical Nurses	17,513	19,224	470,210	24.46	4
5	CNAs & Orderlies	77,175	84,010	1,176,220	14.00	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	3,332	3,676	63,290	17.22	9
10	Activity Assistants	18,313	19,793	200,567	10.13	10
11	Social Service Workers	5,948	6,336	89,861	14.18	11
12	Dietician	1,828	2,080	48,242	23.19	12
13	Food Service Supervisor	2,920	3,115	35,508	11.40	13
14	Head Cook	7,181	7,644	80,331	10.51	14
15	Cook Helpers/Assistants	29,780	31,492	261,306	8.30	15
16	Dishwashers					16
17	Maintenance Workers	6,538	7,072	127,372	18.01	17
18	Housekeepers	16,835	17,899	157,027	8.77	18
19	Laundry	5,384	5,923	55,694	9.40	19
20	Administrator	1,928	2,080	102,627	49.34	20
21	Assistant Administrator	1,896	2,080	55,122	26.50	21
22	Other Administrative	1,755	2,099	52,441	24.98	22
23	Office Manager	3,760	4,000	67,542	16.89	23
24	Clerical	6,184	6,909	70,031	10.14	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>	1,200	1,328	20,678	15.57	33
34	TOTAL (lines 1 - 33)	232,651	252,001	\$ 3,912,578 *	\$ 15.53	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	202	\$ 16,273	1,3	35
36	Medical Director	1750/mo	19,250	9,3	36
37	Medical Records Consultant	16	920	10,3	37
38	Nurse Consultant	367	3,044	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	44	3,378	11,3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	629	\$ 42,864		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	553	\$ 22,693	10,3	50
51	Licensed Practical Nurses	3,636	130,886	10,3	51
52	Certified Nurse Assistants/Aides	1,436	27,288	10,3	52
53	TOTAL (lines 50 - 52)	5,625	\$ 180,867		53

Facility Name & ID Number Provena Cor Mariae Center

0041046

Report Period Beginning: 01/01/07

Ending: 12/31/07

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Teresa Wester-Peters	Administrator	0	\$ 102,672	Workers' Compensation Insurance	\$ 109,920	IDPH License Fee	\$	
Administrative Staff	Admissions	0	66,118	Unemployment Compensation Insurance	21,720	Advertising: Employee Recruitment		
Administrative Staff	Human Resource	0	36,102	FICA Taxes	284,086	Health Care Worker Background Check		
Administrative Staff	Admin Asst	0	31,364	Employee Health Insurance	283,257	(Indicate # of checks performed <u>105</u>)		
Administrative Staff	Receptionist	0	28,544	Employee Meals		Patient Background Checks	<u>313</u>	
Administrative Staff	Office Manager	0	31,440	Illinois Municipal Retirement Fund (IMRF)*		Employee Recruitment	12,459	
Administrative Staff	Asst Administrator	0	51,522	Life Insurance	21,832	Dues & Subscription	11,542	
TOTAL (agree to Schedule V, line 17, col. 1)				Pension	115,828	Advertising & Public Relations	51,440	
(List each licensed administrator separately.)			\$ 347,762	Employee Recognition	1,138			
B. Administrative - Other				Executive Benefits	6,943	Home Office Allocation	9,578	
Description			Amount	Employment Screenings	15,843	Less: Public Relations Expense	()	
Corporate Service Fee			\$ 115,560	Home Office Allocation	104,199	Non-allowable advertising	(47,969)	
Corporate Fee			164,400			Yellow page advertising	()	
Mgmt Fee			415,920	TOTAL (agree to Schedule V, line 22, col.8)			\$ 964,766	
Mngt Fee Interest			215,160	E. Schedule of Non-Cash Compensation Paid to Owners or Employees				
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 911,040	Description	Line #	Amount		
(Attach a copy of any management service agreement)				N/A		\$		
C. Professional Services				G. Schedule of Travel and Seminar**				
Vendor/Payee	Type		Amount	Description			Amount	
Legal Expense	Various		\$ 3,535	Out-of-State Travel			\$ 510	
Collection Expense	Various		773					
Shredding	Various		908					
Survey & Analytical Tools	Various		10,276	In-State Travel			15,065	
Outsourced Services	Various		282					
				Seminar Expense				
				Home Office Allocation			7,139	
				Entertainment Expense			()	
				(agree to Sch. V, line 24, col. 8)				
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			\$ 22,714	
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 15,774					

* Attach copy of IMRF notifications

**See instructions.

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Life Service Network \$6,504
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? Yes If YES, what is the capacity? 162
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 7 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 28,171 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. \$ 39,888
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? No Indicate the amount. \$ None
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? Yes
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.