

		FOR BHF USE					

LL1

**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:** 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 01/01/07 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.

<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 # ( ) _____	

**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 St Joseph Center

# 0041871 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	120	Skilled (SNF)	120	43,800	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	120	TOTALS	120	43,800	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				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	18,316	14,304	3,690	36,310	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,316	14,304	3,690	36,310	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.90%

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 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 3,690

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 St Joseph Center # 0041871 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	
	<b>A. General Services</b>											
1	Dietary	306,385	29,986	14,509	350,880		350,880		350,880			1
2	Food Purchase		179,734		179,734		179,734	(35,338)	144,396			2
3	Housekeeping	125,564	20,627		146,191		146,191		146,191			3
4	Laundry	1,834	4,826	114,841	121,501		121,501		121,501			4
5	Heat and Other Utilities			243,131	243,131		243,131	1,412	244,543			5
6	Maintenance	90,660	21,775	65,529	177,964		177,964	17,438	195,402			6
7	Other (specify):* <b>Pastoral Care</b>	17,771	776	28,283	46,830		46,830	28,080	74,910			7
8	<b>TOTAL General Services</b>	542,214	257,724	466,293	1,266,231		1,266,231	11,592	1,277,823			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	1,941,693	117,420	115,356	2,174,469		2,174,469		2,174,469			10
10a	Therapy			270,673	270,673		270,673		270,673			10a
11	Activities	81,762	1,089	4,011	86,862		86,862	441	87,303			11
12	Social Services	27,713	179	810	28,702		28,702		28,702			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	<b>TOTAL Health Care and Programs</b>	2,051,168	118,688	402,850	2,572,706		2,572,706	441	2,573,147			16
	<b>C. General Administration</b>											
17	Administrative	216,824	20,543	681,120	918,487		918,487	(195,642)	722,845			17
18	Directors Fees											18
19	Professional Services			27,034	27,034		27,034	125,382	152,416			19
20	Dues, Fees, Subscriptions & Promotions			51,411	51,411		51,411	(20,244)	31,167			20
21	Clerical & General Office Expenses			149,466	149,466		149,466	7,679	157,145			21
22	Employee Benefits & Payroll Taxes			721,598	721,598		721,598	78,689	800,287			22
23	Inservice Training & Education			11,052	11,052		11,052	3,664	14,716			23
24	Travel and Seminar			12,842	12,842		12,842	5,234	18,076			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			103,560	103,560		103,560	966	104,526			26
27	Other (specify):* <b>Bad Debt</b>			(12,128)	(12,128)		(12,128)	12,128				27
28	<b>TOTAL General Administration</b>	216,824	20,543	1,745,955	1,983,322		1,983,322	17,856	2,001,178			28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,810,206	396,955	2,615,098	5,822,259		5,822,259	29,889	5,852,148			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: 01/01/07 Ending: 12/31/07

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	<b>D. Ownership</b>											
30	Depreciation			220,984	220,984	220,984	101,177	322,161				30
31	Amortization of Pre-Op. & Org.											31
32	Interest						148,891	148,891				32
33	Real Estate Taxes			99,997	99,997	99,997		99,997				33
34	Rent-Facility & Grounds						12,560	12,560				34
35	Rent-Equipment & Vehicles			4,703	4,703	4,703	1,709	6,412				35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			325,684	325,684	325,684	264,337	590,021				37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			267,874	267,874	267,874	(160,936)	106,938				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			65,520	65,520	65,520		65,520				42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			333,394	333,394	333,394	(160,936)	172,458				44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,810,206	396,955	3,274,176	6,481,337	6,481,337	133,290	6,614,627				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:

01/01/07

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	(38,420)	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	19,265	30		9
10	Interest and Other Investment Income	(5,367)	32		10
11	Discounts, Allowances, Rebates & Refunds	(160,936)	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	12,128	27		24
25	Fund Raising, Advertising and Promotional	(27,267)	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>	\$ (200,597)		\$	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)	305,807		34
35	Other- Attach Schedule	(28,080)		35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 277,727		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ 77,130		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	<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: 01/01/07

Ending: 12/31/07

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Development - Publications	\$ 1,817	7	1
2	Development - Misc.	26,263	7	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	28,080		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Provena St Joseph Center

# 0041871

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)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(38,420)	3,082	0	0	0	0	0	0	0	0	0	(35,338)	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	1,412	0	0	0	0	0	0	0	0	0	1,412	5
6	Maintenance	0	371	17,067	0	0	0	0	0	0	0	0	17,438	6
7	Other (specify):*	28,080	0	0	0	0	0	0	0	0	0	0	28,080	7
8	<b>TOTAL General Services</b>	<b>(10,340)</b>	<b>4,865</b>	<b>17,067</b>	<b>0</b>	<b>11,592</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	441	0	0	0	0	0	0	0	0	0	441	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>441</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>441</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	(302,249)	106,607	0	0	0	0	0	0	0	0	(195,642)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	50,905	74,477	0	0	0	0	0	0	0	0	125,382	19
20	Fees, Subscriptions & Promotions	(27,267)	7,023	0	0	0	0	0	0	0	0	0	(20,244)	20
21	Clerical & General Office Expenses	0	7,679	0	0	0	0	0	0	0	0	0	7,679	21
22	Employee Benefits & Payroll Taxes	0	40,881	37,808	0	0	0	0	0	0	0	0	78,689	22
23	Inservice Training & Education	0	3,664	0	0	0	0	0	0	0	0	0	3,664	23
24	Travel and Seminar	0	5,234	0	0	0	0	0	0	0	0	0	5,234	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	966	0	0	0	0	0	0	0	0	0	966	26
27	Other (specify):*	12,128	0	0	0	0	0	0	0	0	0	0	12,128	27
28	<b>TOTAL General Administration</b>	<b>(15,139)</b>	<b>(185,897)</b>	<b>218,892</b>	<b>0</b>	<b>17,856</b>	<b>28</b>							
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(25,479)</b>	<b>(180,591)</b>	<b>235,959</b>	<b>0</b>	<b>29,889</b>	<b>29</b>							

STATE OF ILLINOIS

Facility Name & ID Number Provena St Joseph Center

# 0041871

Report Period Beginning:

01/01/07

Ending:

Summary B

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	19,265	0	81,912	0	0	0	0	0	0	0	0	101,177	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(5,367)	0	154,258	0	0	0	0	0	0	0	0	148,891	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	12,560	0	0	0	0	0	0	0	0	12,560	34
35	Rent-Equipment & Vehicles	0	0	1,709	0	0	0	0	0	0	0	0	1,709	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>13,898</b>	<b>0</b>	<b>250,439</b>	<b>0</b>	<b>264,337</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	(160,936)	0	0	0	0	0	0	0	0	0	0	(160,936)	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>(160,936)</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>(160,936)</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(172,517)</b>	<b>(180,591)</b>	<b>486,398</b>	<b>0</b>	<b>133,290</b>	<b>45</b>							

Facility Name & ID Number Provena St Joseph Center

# 0041871

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%	\$ 3,082	\$ 3,082 1
2	V	5 Utilities		Provena Senior Services	100.00%	1,412	1,412 2
3	V	6 Maintenance - Other		Provena Senior Services	100.00%	371	371 3
4	V	11 Activities-Special Events		Provena Senior Services	100.00%	441	441 4
5	V	17 Admin - Misc. Other	462,720	Provena Senior Services	100.00%	9,229	(453,491) 5
6	V	17 Administrative Salaries		Provena Senior Services	100.00%	151,242	151,242 6
7	V	19 Professional Services		Provena Senior Services	100.00%	50,905	50,905 7
8	V	20 Dues,Subscriptions		Provena Senior Services	100.00%	7,023	7,023 8
9	V	21 Clerical Supplies		Provena Senior Services	100.00%	7,679	7,679 9
10	V	22 Employee Benefits		Provena Senior Services	100.00%	40,881	40,881 10
11	V	23 Education/Conference		Provena Senior Services	100.00%	3,664	3,664 11
12	V	24 Travel		Provena Senior Services	100.00%	5,234	5,234 12
13	V	26 Insurance		Provena Senior Services	100.00%	966	966 13
14	Total		\$ 462,720			\$ 282,129	\$ * (180,591) 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: 01/01/07Ending: 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%	\$ 2,727	\$ 2,727	15
16	V	32 Interest		Provena Senior Services	100.00%	154,258	154,258	16
17	V	34 Rent - Facility		Provena Senior Services	100.00%	12,560	12,560	17
18	V	35 Rent - Equipment		Provena Senior Services	100.00%	1,709	1,709	18
19	V	17 Admin Salaries	90,240	Provena Health Services	100.00%	72,464	(17,776)	19
20	V	22 Employee Benefits		Provena Health Services	100.00%	17,056	17,056	20
21	V	30 Depreciation		Provena Health Services	100.00%	79,185	79,185	21
22	V	19 Admin Consulting, Other		Provena Health Services	100.00%	74,477	74,477	22
23	V	17 Information Systems Salaries	128,160	Provena Health Services	100.00%	24,661	(103,499)	23
24	V	22 Information Systems Benefits		Provena Health Services	100.00%	5,655	5,655	24
25	V	17 Information Systems - Other		Provena Health Services	100.00%	163,746	163,746	25
26	V	17 Admin Salaries		Provena Health Services	100.00%	34,488	34,488	26
27	V	22 Employee Benefits		Provena Health Services	100.00%	8,118	8,118	27
28	V	17 Information Systems Salaries		Provena Health Services	100.00%	29,648	29,648	28
29	V	22 Information Systems Benefits		Provena Health Services	100.00%	6,979	6,979	29
30	V	6 Information Systems - Equip Maint		Provena Health Services	100.00%	17,067	17,067	30
31	V	39 Ancillary Services - Other	267,874	Provena Senior Services Pharmacy	100.00%	267,874		31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 486,274			\$ 972,672	\$ * 486,398	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:

01/01/07

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 St Joseph Center

# 0041871

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	\$	462,720	\$ 3,082	1
2	5	Utilities	Management Fee Income 6,620,619	19	20,208		462,720	1,412	2
3	6	Maintenance - Other	Management Fee Income 6,620,619	19	5,313		462,720	371	3
4	11	Activities-Special Events	Management Fee Income 6,620,619	19	6,306		462,720	441	4
5	17	Admin - Misc. Other	Management Fee Income 6,620,619	19	132,045		462,720	9,229	5
6	17	Administrative Salaries	Management Fee Income 6,620,619	19	2,163,976	2,163,976	462,720	151,242	6
7	19	Professional Services	Management Fee Income 6,620,619	19	728,345		462,720	50,905	7
8	20	Dues,Subscriptions	Management Fee Income 6,620,619	19	100,486		462,720	7,023	8
9	21	Clerical Supplies	Management Fee Income 6,620,619	19	109,877		462,720	7,679	9
10	22	Employee Benefits	Management Fee Income 6,620,619	19	584,930		462,720	40,881	10
11	23	Education/Conference	Management Fee Income 6,620,619	19	52,430		462,720	3,664	11
12	24	Travel	Management Fee Income 6,620,619	19	74,891		462,720	5,234	12
13	26	Insurance	Management Fee Income 6,620,619	19	13,824		462,720	966	13
14	30	Depreciation	Management Fee Income 6,620,619	19	39,013		462,720	2,727	14
15	32	Interest	Management Fee Income 6,620,619	19	2,207,136		462,720	154,258	15
16	34	Rent - Facility	Management Fee Income 6,620,619	19	179,713		462,720	12,560	16
17	35	Rent - Equipment	Management Fee Income 6,620,619	19	24,448		462,720	1,709	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 6,487,041	\$ 2,163,976		\$ 453,383	25

Facility Name & ID Number Provena St Joseph Center

# 0041871

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	90,240	\$ 72,464	1
2	22	Employee Benefits	Operating Expense	1,239,804	10	234,337		90,240	17,056	2
3	30	Depreciation	Operating Expense	1,239,804	10	1,087,913		90,240	79,185	3
4	19	Admin Consulting,Other	Operating Expense	1,239,804	10	1,023,231		90,240	74,477	4
5	17	Information Systems Salaries	Operating Expense	1,759,764	10	338,615	338,615	128,160	24,661	5
6	22	Information Systems Benefits	Operating Expense	1,759,764	10	77,649		128,160	5,655	6
7	17	Information Systems - Other	Operating Expense	1,759,764	10	2,248,393		128,160	163,746	7
8	17	Admin Salaries	Direct Cost	1,239,804	10	473,834	473,834	90,240	34,488	8
9	22	Employee Benefits	Direct Cost	1,239,804	10	111,529		90,240	8,118	9
10	17	Information Systems Salaries	Direct Cost	1,759,764	10	407,099	407,099	128,160	29,648	10
11	22	Information Systems Benefits	Direct Cost	1,759,764	10	95,822		128,160	6,979	11
12	6	Information Systems - Equip Main	Direct Cost	1,759,764	10	234,347		128,160	17,067	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		\$ 533,544	25

Facility Name & ID Number Provena St Joseph Center

# 0041871 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		\$	\$		\$ 267,874	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				\$	\$		\$ 267,874	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	Home Office Allocation									\$ 154,258	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>					\$	\$			\$ 154,258	9									
<b>B. Non-Facility Related*</b>																				
10											10									
11											11									
12											12									
13											13									
14	<b>TOTAL Non-Facility Related</b>					\$	\$			\$	14									
15	<b>TOTALS (line 9+line14)</b>					\$	\$			\$ 154,258	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 2006 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 2007 report. (Detail and explain your calculation of this accrual on the lines below.)			\$ <b>99,997</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>99,997</b>	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:				
2002	_____	<b>8</b>		
2003	_____	<b>9</b>		
2004	_____	<b>10</b>		
2005	_____	<b>11</b>		
2006	_____	<b>12</b>		
			<b>FOR BHF USE ONLY</b>	
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 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 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>To be determined</u>	<u></u>	\$ <u>99,997.00</u>	\$ <u>99,997.00</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>99,997.00</u>	\$ <u>99,997.00</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 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 St Joseph Center

# 0041871 Report Period Beginning:

01/01/07 Ending:

12/31/07

**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).

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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 & ID Number Provena St Joseph Center

# 0041871

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		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	120		1996	1994	\$ 2,500,000	\$ 62,500	40	\$ 62,500		\$ 718,750	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	Various		1996		3,510	175	10	175		3,510	9
10	Various		1997		30,114	1,135	7	1,135		25,005	10
11	Various		1998		6,818	372	7	372		6,632	11
12	Various		1999		83,407	5,906	11	5,906		52,280	12
13	Various		2000		10,770	41	5	41		10,770	13
14	Various		2001		26,516	827	7	827		21,000	14
15	Various		2002		45,550	4,143	10	4,143		31,894	15
16	Various		2003		80,759	7,619	11	7,619		34,365	16
17											17
18	PAINTING OF CHAPEL		2004		9,500	1,900	5	1,900		6,650	18
19	CARPET AND LABOR		2004		7,030	1,406	5	1,406		4,921	19
20	TELEPHONE SYSTEM		2004		5,303	530	10	530		1,856	20
21	PLASTER WORK IN LARGE CH		2004		5,150	515	10	515		1,803	21
22	HEAT EXCHANGE FOR MAIN B		2004		4,983	498	10	498		1,744	22
23	BOILER REPLACEMENT		2004		2,227	111	20	111		445	23
24	BOILER REPAIR		2004		1,766	177	10	177		618	24
25	ADD SPRINKLER TO STORAGE		2004		1,680	112	15	112		392	25
26	CLF BATH AND SHOWER UPGR		2004		1,414	141	10	141		566	26
27	BOILER REPAIR		2004		1,355	90	15	90		316	27
28	BOILER REPAIR		2004		1,015	102	10	102		355	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 &amp; ID Number Provena St Joseph Center

# 0041871

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	BOILER AT ONEILL HALL/RE	2005	\$ 30,950	\$ 1,548	20	\$ 1,548	\$	\$ 3,869	37
38	REPLACE FIREBOARD FOR AD	2005	21,223	2,122	10	2,122		5,306	38
39	SEWER LINE	2005	18,420	921	20	921		2,303	39
40	REPAIR UNDERGROUND STEAM	2005	6,710	671	10	671		1,678	40
41	AUTOMATIC DOOR EQUIPMENT	2005	6,284	628	10	628		1,571	41
42	INSTALLATION OF LARGE FL	2005	5,850	585	10	585		1,463	42
43	ASPHALT - CLF PROGRAM	2005	2,364	295	8	295		739	43
44	51" TOSHIBA HDTV MONITOR	2005	1,499	300	5	300		750	44
45	REMOVAL OF WALL IN TV LO	2005	965	97	10	97		241	45
46	TOWER ROOF REPAIRS	2005	795	80	10	80		239	46
47	REPLACE FIREBOARD FOR AD	2005	697	70	10	70		174	47
48	CARPETING	2005	563	113	5	113		282	48
49									49
50	FIRE SPRINKLER	2006	7,155	477	15	477		683	50
51	HIGH EFFICIENCY FURNACE	2006	7,125	475	15	475		713	51
52	REPAIR LOADING DOCK AREA	2006	3,664	458	8	458		687	52
53	WIRE KITCHEN RANGE HOOD	2006	3,405	341	10	341		681	53
54	SIDEWALK REPLACEMENT	2006	2,596	173	15	173		197	54
55	FLOORING FOR KITCHENETTE	2006	2,595	519	5	519		779	55
56	TREE REMOVAL	2006	2,500	500	5	500		750	56
57	RECOVER 2 L SHAPED AWNIN	2006	2,380	238	10	238		357	57
58	TRINITY HOUSE CARPETING	2006	1,741	348	5	348		522	58
59	PATCH CEILINGS IN HALLWAY	2006	800	80	10	80		120	59
60	LANDSCAPING - REMOVAL OF	2006	800	80	10	80		120	60
61	LANDSCAPING	2006	554	55	10	55		95	61
62	SEWER LINE FROM HOUSE TO	2006	116	39	3	39		58	62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,960,618	\$ 99,513		\$ 99,513	\$	\$ 948,245	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:

01/01/07

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		\$ 2,960,618	\$ 99,513		\$ 99,513	\$	\$ 948,245	1
2	ACCUTECH WANDERING AND V	2007	27,827	1,391	10	2,783	1,391	1,391	2
3	LOBBY REMODEL	2007	24,214	807	15	1,614	807	807	3
4	REWIRING OF ELECTRICAL F	2007	15,690	392	20	785	392	392	4
5	RENOVATION OF CHAPEL	2007	14,278	952	15	1,904	952	952	5
6	DINING ROOM PAINTING	2007	9,075	908	5	1,815	908	908	6
7	CULTURAL REMODEL	2007	6,337	317	10	634	317	317	7
8	LANDSCAPING	2007	6,331	633	10	1,266	633	633	8
9	PAINTING OF NURSING HOME	2007	6,264	626	5	1,253	626	626	9
10	PT/OT REMODELING	2007	5,369	179	15	358	179	179	10
11	BOILER REPAIRS	2007	3,509	501	7	1,003	501	501	11
12	ENTRANCE CANOPY	2007	665	33	10	67	33	33	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)		\$ 3,080,177	\$ 106,252		\$ 112,992	\$ 6,740	\$ 954,985	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: 01/01/07 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	\$ 748,352	\$ 93,638	\$ 93,638	\$	10	\$ 222,146	71
72	Current Year Purchases	156,830	10,569	21,138	10,569	10	10,569	72
73	Fully Depreciated Assets	498,633				5	498,633	73
74	Home Office Allocation		81,912	81,912				74
75	TOTALS	\$ 1,403,815	\$ 186,119	\$ 196,688	\$ 10,569		\$ 731,348	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	1997 Dodge 2500	1997	\$ 24,090	\$	\$	\$	5	\$ 24,090	76
77	Plant Engineering	2001 Mercury Sable	2001	23,123				3	23,123	77
78	Plant Engineering	2003 Ford Van	2004	34,275	8,569	8,569		4	29,991	78
79	Plant Engineering	2006 Chevy Uplander	2007	15,649	1,956	3,912	1,956	4	1,956	79
80	TOTALS			\$ 97,137	\$ 10,525	\$ 12,481	\$ 1,956		\$ 79,160	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)	\$ 5,981,129	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 302,896	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 322,161	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 19,265	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,765,493	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				12,560			5
6					_____			6
7	<b>TOTAL</b>				\$ 12,560			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: \$ 30,182 Description: Nursing \$23500, Plant Eng. \$270, Admin. \$4703. Home Office \$1709  
(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	<b>TOTAL</b>		\$ _____	\$ _____	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	\$	2,429	\$ 131,147	\$	2,429	\$ 131,147	1
2	Licensed Speech and Language Development Therapist	10a, 3	hrs		143	7,718		143	7,718	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a, 3	hrs		2,441	131,808		2,441	131,808	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				267,874		267,874	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	<b>TOTAL</b>			\$	5,012	\$ 270,673	\$ 267,874	5,012	\$ 538,547	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: 01/01/07

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*	
	<b>A. Current Assets</b>			
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	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 20,759,191	\$	10
	<b>B. Long-Term Assets</b>			
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	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 65,780,207	\$	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 86,539,398	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
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
	<b>Other Current Liabilities(specify):</b>			
36	<u>Due to Related Party</u>	817,281		36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 11,248,905	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	1,247,620		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	338,908		42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>Conditional Asset Retirement</u>	450,209		43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 2,036,737	\$	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 13,285,642	\$	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 73,253,756	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (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	2,454,477	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 73,595,210	6
	<b>A. Additions (deductions):</b>		
7	NET Income (Loss) (from page 19, line 43)	(224,782)	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)	\$ (341,454)	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)	\$ 73,253,756	24 *

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

Facility Name & ID Number Provena St Joseph Center# 0041871Report 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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 4,846,548	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 4,846,548	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	476,045	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 476,045	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	38,420	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	217,587	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>	\$ 256,007	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	515,888	24
25	Interest and Other Investment Income***	5,367	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 521,255	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Purchase Rebates</u>	160,936	28
28a	<u>Misc. Income</u>	1,808	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 162,744	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 6,262,599	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,366,228	31
32	Health Care	2,572,706	32
33	General Administration	1,983,322	33
<b>B. Capital Expense</b>			
34	Ownership	225,687	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	267,874	35
36	Provider Participation Fee	65,520	36
<b>D. Other Expenses (specify):</b>			
37	<u>Loss on SOFA</u>	6,044	37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 6,487,381	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(224,782)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (224,782)	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:

01/01/07

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	1,816	2,080	\$ 78,909	\$ 37.94	1
2	Assistant Director of Nursing	1,828	2,080	58,376	28.07	2
3	Registered Nurses	6,696	9,683	250,760	25.90	3
4	Licensed Practical Nurses	28,639	30,561	578,898	18.94	4
5	CNAs & Orderlies	79,607	83,106	907,155	10.92	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,774	6,256	67,595	10.80	8
9	Activity Director	1,868	2,080	29,673	14.27	9
10	Activity Assistants	5,268	5,678	52,089	9.17	10
11	Social Service Workers	2,343	2,559	27,713	10.83	11
12	Dietician	1,844	2,080	42,845	20.60	12
13	Food Service Supervisor	2,159	2,326	26,164	11.25	13
14	Head Cook	5,348	5,684	51,334	9.03	14
15	Cook Helpers/Assistants	21,748	23,619	186,042	7.88	15
16	Dishwashers					16
17	Maintenance Workers	6,214	6,804	90,660	13.32	17
18	Housekeepers	13,794	14,571	125,564	8.62	18
19	Laundry	225	265	1,834	6.92	19
20	Administrator	1,856	2,080	68,747	33.05	20
21	Assistant Administrator	984	1,008	11,931	11.84	21
22	Other Administrative	2,460	2,761	41,826	15.15	22
23	Office Manager	2,692	3,040	32,157	10.58	23
24	Clerical	5,274	5,728	62,163	10.85	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>	1,448	1,705	17,771	10.42	33
34	TOTAL (lines 1 - 33)	199,885	215,754	\$ 2,810,206 *	\$ 13.03	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	188	\$ 14,126	1,3	35
36	Medical Director	\$1000/mo	12,000	9,3	36
37	Medical Records Consultant				37
38	Nurse Consultant	129	10,034	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	17	828	11,3	44
45	Social Service Consultant	14	810	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	348	\$ 37,798		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	33	\$ 1,302	10,3	50
51	Licensed Practical Nurses	1,161	44,113	10,3	51
52	Certified Nurse Assistants/Aides	742	16,327	10,3	52
53	TOTAL (lines 50 - 52)	1,936	\$ 61,742		53

Facility Name & ID Number Provena St Joseph Center

# 0041871

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	
Theresa Parsek	Administrator	0	\$ 68,747	Workers' Compensation Insurance	\$ 85,680	IDPH License Fee	\$	
Administrative Staff	Asst. Administrator	0	11,931	Unemployment Compensation Insurance	20,310	Advertising: Employee Recruitment		
Administrative Staff	Bookkeeper	0	20,045	FICA Taxes	204,907	Health Care Worker Background Check		
Administrative Staff	Admissions	0	41,826	Employee Health Insurance	278,450	(Indicate # of checks performed <u>63</u> )		
Administrative Staff	Receptionist	0	41,449	Employee Meals		Patient Background Checks	<u>103</u>	
Administrative Staff	Admini Asst	0	20,714	Illinois Municipal Retirement Fund (IMRF)*		Employee Recruitment	7,951	
Administrative Staff	Human Resources	0	12,112	Life Insurance	14,884	Dues & Subscriptions	12,788	
TOTAL (agree to Schedule V, line 17, col. 1)				Pension	97,241	Advertising & Public Relations	30,672	
(List each licensed administrator separately.)			\$ 216,824	Employee Recognition	2,481			
B. Administrative - Other				Executive Benefits	7,516	Home Office Allocation	7,023	
Description			Amount	Employee Screenings	10,129	Less: Public Relations Expense	( )	
Corp Service Fee			\$ 90,240	Home Office Allocation	78,689	Non-allowable advertising	(27,267)	
Corp Service IS Fee			128,160			Yellow page advertising	( )	
Mgmt Fee			324,360	TOTAL (agree to Schedule V, line 22, col.8)			\$ 800,287	
Mgmt Fee Interest			138,360					
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 681,120					
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
C. Professional Services				Description	Line #	Amount	Description	Amount
Vendor/Payee	Type		Amount	N/A		\$	Out-of-State Travel	\$
Legal Expense	Various		\$ 13,256					
Survey & Analytical Tools	Various		7,075				In-State Travel	12,842
Medical Waste	Various		2,841					
Living Design	Various		947				Seminar Expense	
Outsourced Services	Various		1,593				Home Office Allocation	5,234
Collection Expense	Various		122					
Plant Maintenance	Various		1,200				Entertainment Expense	( )
							(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 18,076
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			\$	
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 27,034					

\* 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 \$5,584
- (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. \$ 18,675 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. \$ 65,520  
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. \$ 38,420
- (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.