

Facility Name & ID Number Provena Cor Mariae Center

0041046 Report Period Beginning: 01/01/08 Ending: 12/31/08

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>26,718</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>32,574</u>	5
6		ICF/DD 16 or Less			6
7	<u>162</u>	TOTALS	<u>162</u>	<u>59,292</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				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	<u>3,818</u>	<u>11,729</u>	<u>10,273</u>	<u>25,820</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC		<u>25,104</u>		<u>25,104</u>	12
13	DD 16 OR LESS					13
14	TOTALS	<u>3,818</u>	<u>36,833</u>	<u>10,273</u>	<u>50,924</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.89%

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 6/5/1995 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 10,273

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/08 Fiscal Year: 12/31/08

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

Facility Name & ID Number Provena Cor Mariae Center # 0041046 Report Period Beginning: 01/01/08 Ending: 12/31/08

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	449,502	86,506	25,482	561,490		561,490		561,490			1
2	Food Purchase		344,312		344,312		344,312	3,653	347,965			2
3	Housekeeping	159,580	32,463	345	192,388		192,388		192,388			3
4	Laundry	53,706	8,188	65,832	127,726		127,726		127,726			4
5	Heat and Other Utilities			363,167	363,167		363,167	3,698	366,865			5
6	Maintenance	137,812	58,131	84,767	280,710		280,710	36,515	317,225			6
7	Other (specify):* Pastoral Care	44,882	2,212	14,911	62,005		62,005	3,600	65,605			7
8	TOTAL General Services	845,482	531,812	554,504	1,931,798		1,931,798	47,466	1,979,264			8
	B. Health Care and Programs											
9	Medical Director			21,000	21,000		21,000		21,000			9
10	Nursing and Medical Records	2,570,176	194,244	188,345	2,952,765		2,952,765		2,952,765			10
10a	Therapy			1,058,225	1,058,225		1,058,225		1,058,225			10a
11	Activities	280,825	21,984	14,511	317,320		317,320	743	318,063			11
12	Social Services	86,562	1,573	533	88,668		88,668		88,668			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,937,563	217,801	1,282,614	4,437,978		4,437,978	743	4,438,721			16
	C. General Administration											
17	Administrative	387,571	63,943	1,011,660	1,463,174		1,463,174	(445,962)	1,017,212			17
18	Directors Fees											18
19	Professional Services			9,675	9,675		9,675	58,169	67,844			19
20	Dues, Fees, Subscriptions & Promotions			61,367	61,367		61,367	(34,768)	26,599			20
21	Clerical & General Office Expenses			71,754	71,754		71,754	10,810	82,564			21
22	Employee Benefits & Payroll Taxes			971,390	971,390		971,390	255,756	1,227,146			22
23	Inservice Training & Education			11,561	11,561		11,561	3,963	15,524			23
24	Travel and Seminar			18,509	18,509		18,509	8,103	26,612			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			102,324	102,324		102,324	563	102,887			26
27	Other (specify):* Bad Debt			(127,656)	(127,656)		(127,656)	127,656				27
28	TOTAL General Administration	387,571	63,943	2,130,584	2,582,098		2,582,098	(15,710)	2,566,388			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,170,616	813,556	3,967,702	8,951,874		8,951,874	32,499	8,984,373			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:

01/01/08

Ending:

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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	
	D. Ownership											
30	Depreciation			405,034	405,034	405,034	110,864	515,898				30
31	Amortization of Pre-Op. & Org.											31
32	Interest						810,634	810,634				32
33	Real Estate Taxes			337	337	337		337				33
34	Rent-Facility & Grounds						24,984	24,984				34
35	Rent-Equipment & Vehicles			9,468	9,468	9,468	3,774	13,242				35
36	Other (specify):*											36
37	TOTAL Ownership			414,839	414,839	414,839	950,256	1,365,095				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			628,227	628,227	628,227	(290,131)	338,096				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			40,077	40,077	40,077		40,077				42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			668,304	668,304	668,304	(290,131)	378,173				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,170,616	813,556	5,050,845	10,035,017	10,035,017	692,624	10,727,641				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: 01/01/08

Ending: 12/31/08

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	14,689	30		9
10	Interest and Other Investment Income	(9,768)	32		10
11	Discounts, Allowances, Rebates & Refunds	(290,131)	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	127,656	27		24
25	Fund Raising, Advertising and Promotional	(44,044)	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)	\$ (201,598)		\$	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)	890,622		34
35	Other- Attach Schedule	3,600		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 894,222		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 692,624		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.

		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					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: 01/01/08

Ending: 12/31/08

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Development - Misc	\$ 3,600	7	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	3,600		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Provena Cor Mariae Center

0041046

Report Period Beginning:

01/01/08

Ending:

12/31/08

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	3,653	0	0	0	0	0	0	0	0	0	3,653	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	3,698	0	0	0	0	0	0	0	0	0	3,698	5
6	Maintenance	0	1,683	34,832	0	0	0	0	0	0	0	0	36,515	6
7	Other (specify):*	3,600	0	0	0	0	0	0	0	0	0	0	3,600	7
8	TOTAL General Services	3,600	9,034	34,832	0	47,466	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	743	0	0	0	0	0	0	0	0	0	743	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	743	0	0	0	0	0	0	0	0	0	743	16
	C. General Administration													
17	Administrative	0	(417,683)	(28,279)	0	0	0	0	0	0	0	0	(445,962)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	38,921	19,248	0	0	0	0	0	0	0	0	58,169	19
20	Fees, Subscriptions & Promotions	(44,044)	9,276	0	0	0	0	0	0	0	0	0	(34,768)	20
21	Clerical & General Office Expenses	0	10,810	0	0	0	0	0	0	0	0	0	10,810	21
22	Employee Benefits & Payroll Taxes	0	69,289	186,467	0	0	0	0	0	0	0	0	255,756	22
23	Inservice Training & Education	0	3,963	0	0	0	0	0	0	0	0	0	3,963	23
24	Travel and Seminar	0	8,103	0	0	0	0	0	0	0	0	0	8,103	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	563	0	0	0	0	0	0	0	0	0	563	26
27	Other (specify):*	127,656	0	0	0	0	0	0	0	0	0	0	127,656	27
28	TOTAL General Administration	83,612	(276,758)	177,436	0	(15,710)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	87,212	(266,981)	212,268	0	32,499	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Provena Cor Mariae Center

0041046

Report Period Beginning:

01/01/08 Ending:

12/31/08

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	14,689	0	96,175	0	0	0	0	0	0	0	0	110,864	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(9,768)	0	820,402	0	0	0	0	0	0	0	0	810,634	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	24,984	0	0	0	0	0	0	0	0	24,984	34
35	Rent-Equipment & Vehicles	0	0	3,774	0	0	0	0	0	0	0	0	3,774	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	4,921	0	945,335	0	950,256	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	(290,131)	0	0	0	0	0	0	0	0	0	0	(290,131)	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	(290,131)	0	0	0	0	0	0	0	0	0	0	(290,131)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(197,998)	(266,981)	1,157,603	0	692,624	45							

Facility Name & ID Number Provena Cor Mariae Center

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Report Period Beginning:

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Ending:

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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%	\$ 3,653	\$ 3,653 1
2	V	5 Utilities		Provena Senior Services	100.00%	3,698	3,698 2
3	V	6 Maintenance - Other		Provena Senior Services	100.00%	1,683	1,683 3
4	V	11 Activities-Special Events		Provena Senior Services	100.00%	743	743 4
5	V	17 Admin - Misc. Other	657,480	Provena Senior Services	100.00%	(1,997)	(659,477) 5
6	V	17 Administrative Salaries		Provena Senior Services	100.00%	241,794	241,794 6
7	V	19 Professional Services		Provena Senior Services	100.00%	38,921	38,921 7
8	V	20 Dues,Subscriptions		Provena Senior Services	100.00%	9,276	9,276 8
9	V	21 Clerical Supplies		Provena Senior Services	100.00%	10,810	10,810 9
10	V	22 Employee Benefits		Provena Senior Services	100.00%	69,289	69,289 10
11	V	23 Education/Conference		Provena Senior Services	100.00%	3,963	3,963 11
12	V	24 Travel		Provena Senior Services	100.00%	8,103	8,103 12
13	V	26 Insurance		Provena Senior Services	100.00%	563	563 13
14	Total		\$ 657,480			\$ 390,499	\$ * (266,981) 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: 01/01/08 Ending: 12/31/08

VII. RELATED PARTIES (continued)

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	30	Depreciation	\$	Provena Senior Services	100.00%	\$ 3,651	\$ 3,651	15
16	V	32	Interest		Provena Senior Services	100.00%	316,533	316,533	16
17	V	34	Rent - Facility		Provena Senior Services	100.00%	24,984	24,984	17
18	V	35	Rent - Equipment		Provena Senior Services	100.00%	3,774	3,774	18
19	V	17	Admin Salaries	138,780	Provena Health Services	100.00%	86,483	(52,297)	19
20	V	22	Employee Benefits		Provena Health Services	100.00%	65,815	65,815	20
21	V	30	Depreciation		Provena Health Services	100.00%	92,524	92,524	21
22	V	19	Admin Consulting, Other		Provena Health Services	100.00%	19,248	19,248	22
23	V	17	Information Systems Salaries	215,400	Provena Health Services	100.00%	150,130	(65,270)	23
24	V	22	Information Systems Benefits		Provena Health Services	100.00%	39,958	39,958	24
25	V	17	Information Systems - Other		Provena Health Services	100.00%	20,377	20,377	25
26	V	17	Admin Salaries		Provena Health Services	100.00%	27,955	27,955	26
27	V	22	Employee Benefits		Provena Health Services	100.00%	43,964	43,964	27
28	V	17	Information Systems Salaries		Provena Health Services	100.00%	40,956	40,956	28
29	V	22	Information Systems Benefits		Provena Health Services	100.00%	36,730	36,730	29
30	V	6	Information Systems - Equip Maint		Provena Health Services	100.00%	34,832	34,832	30
31	V	32	Admin - Interest Expense		Provena Health Services	100.00%	503,869	503,869	31
32	V	39	Ancillary Services - Other	628,227	Provena Senior Services Pharmacy	100.00%	628,227		32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 982,407				\$ 2,140,010	\$ * 1,157,603	39

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

Facility Name & ID Number

Provena Cor Mariae Center

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Report Period Beginning:

01/01/08

Ending:

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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: 01/01/08

Ending: 12/31/08

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 6,616,778	19	\$ 36,766	\$	657,480	\$ 3,653	1
2	5	Utilities	Management Fee Income 6,616,778	19	37,212		657,480	3,698	2
3	6	Maintenance - Other	Management Fee Income 6,616,778	19	16,939		657,480	1,683	3
4	11	Activities-Special Events	Management Fee Income 6,616,778	19	7,482		657,480	743	4
5	17	Admin - Misc. Other	Management Fee Income 6,616,778	19	(20,102)		657,480	(1,997)	5
6	17	Administrative Salaries	Management Fee Income 6,616,778	19	2,433,377	2,433,377	657,480	241,794	6
7	19	Professional Services	Management Fee Income 6,616,778	19	391,693		657,480	38,921	7
8	20	Dues,Subscriptions	Management Fee Income 6,616,778	19	93,352		657,480	9,276	8
9	21	Clerical Supplies	Management Fee Income 6,616,778	19	108,789		657,480	10,810	9
10	22	Employee Benefits	Management Fee Income 6,616,778	19	697,316		657,480	69,289	10
11	23	Education/Conference	Management Fee Income 6,616,778	19	39,879		657,480	3,963	11
12	24	Travel	Management Fee Income 6,616,778	19	81,549		657,480	8,103	12
13	26	Insurance	Management Fee Income 6,616,778	19	5,664		657,480	563	13
14	30	Depreciation	Management Fee Income 6,616,778	19	36,741		657,480	3,651	14
15	32	Interest	Management Fee Income 6,616,778	19	3,185,539		657,480	316,533	15
16	34	Rent - Facility	Management Fee Income 6,616,778	19	251,434		657,480	24,984	16
17	35	Rent - Equipment	Management Fee Income 6,616,778	19	37,982		657,480	3,774	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 7,441,612	\$ 2,433,377		\$ 739,441	25

Facility Name & ID Number Provena Cor Mariae Center

0041046

Report Period Beginning:

01/01/08

Ending: 12/31/08

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	17	Admin Salaries	Operating Expense	1,391,394	9	\$ 867,070	\$ 867,070	138,780	\$ 86,483	1
2	22	Employee Benefits	Operating Expense	1,391,394	9	659,854		138,780	65,815	2
3	30	Depreciation	Operating Expense	1,391,394	9	927,633		138,780	92,524	3
4	34	Rent Facility	Operating Expense	1,391,394	9	192,975		138,780	19,248	4
5	19	Admin Consulting,Other	Operating Expense	1,391,394	9	1,505,183		138,780	150,130	5
6	17	Information Systems Salaries	Operating Expense	2,155,920	9	399,935	399,935	215,400	39,958	6
7	22	Information Systems Benefits	Operating Expense	2,155,920	9	203,956		215,400	20,377	7
8	17	Information Systems - Other	Operating Expense	2,155,920	9	279,796		215,400	27,955	8
9	17	Admin Salaries	Direct Cost	1,391,394	9	440,776	440,776	138,780	43,964	9
10	17	Information Systems Salaries	Direct Cost	2,155,920	9	409,925	409,925	215,400	40,956	10
11	6	Information Systems - Equip Main	Direct Cost	2,155,920	9	367,627		215,400	36,730	11
12	19	Admin Consulting,Other	Direct Cost	1,391,394	9	349,224		138,780	34,832	12
13	32	Admin - Interest Expense	Direct Cost	1,391,394	9	5,051,741		138,780	503,869	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					\$ 11,655,695	\$ 2,117,706		\$ 1,162,841	25

Facility Name & ID Number Provena Cor Mariae Center

0041046

Report Period Beginning: 01/01/08

Ending: 12/31/08

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		\$	\$		\$ 628,227	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				\$	\$		\$ 628,227	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	Home Office Allocation									\$ 316,533	1									
2											2									
3											3									
4											4									
5											5									
Working Capital																				
6											6									
7											7									
8											8									
9	TOTAL Facility Related					\$	\$			\$ 316,533	9									
B. Non-Facility Related*																				
10											10									
11											11									
12											12									
13											13									
14	TOTAL Non-Facility Related					\$	\$			\$	14									
15	TOTALS (line 9+line14)					\$	\$			\$ 316,533	15									

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

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

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

2007 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 2007 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 2007.

(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>1,094.17</u>	\$ <u>1,094.17</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>1,094.17</u>	\$ <u>1,094.17</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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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:

01/01/08 Ending:

12/31/08

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:

01/01/08

Ending:

12/31/08

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		\$ 485,000	4
5	63			1997	2,508,246	62,711	40	62,711		705,304	5
6	10			2005	955,154	38,384	25	38,384		132,488	6
7											7
8											8
Improvement Type**											
9				1995	171,813	8,616	18	8,616		112,067	9
10				1996	374,066	18,542	15	18,542		245,600	10
11				1997	251,717	10,721	14	10,721		176,371	11
12				1998	174,397	5,239	13	5,239		72,233	12
13				1999	10,976	45	6	45		10,953	13
14				2000	39,900	1,176	6	1,176		38,136	14
15				2001	48,414	3,380	9	3,380		31,616	15
16				2002	118,018	9,346	10	9,346		64,962	16
17				2003	128,140	22,261	10	22,261		111,120	17
18				2004	106,296	11,607	9	11,607		54,209	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:

01/01/08

Ending:

12/31/08

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	REROOF MAINTENANCE SHOP	2005	\$ 21,947	\$ 2,195	10	\$ 2,195	\$	\$ 8,779	37
38	TEKNOFLOR#73803 SHEET VI	2005	8,780	878	10	878		3,073	38
39	LANDSCAPING	2005	5,950	595	10	595		2,083	39
40	RELOCATION OF UNDERGROUN	2005	5,736	382	15	382		1,338	40
41	PARTS/LABOR TO REPLACE W	2005	5,730	573	10	573		2,006	41
42	EXTERNAL SIGNAGE	2005	3,000	300	10	300		1,050	42
43	TEKNOFLOR IN SKILLED NUR	2005	2,170	310	7	310		1,085	43
44	SIGNAGE	2005	1,914	191	10	191		670	44
45	MVP WATER SOFTENER	2005	1,658	166	10	166		663	45
46	INSTALL BURN THROW DOOR	2005	818	82	10	82		327	46
47									47
48									48
49									49
50	PATIO ROOF /FRONT ENTRAN	2006	42,366	4,237	10	4,237		10,592	50
51	FENCING INSTALLATION	2006	35,687	2,974	12	2,974		7,435	51
52	COOLING TOWER REPLACEMEN	2006	33,800	2,253	15	2,253		5,633	52
53	WATERMAIN REPAIR	2006	3,512	351	10	351		1,054	53
54									54
55	SHELTERED CARE SHOWER	2007	23,500	1,567	15	1,567		3,133	55
56	BATHROOM REMODEL	2007	20,454	1,364	15	1,364		1,857	56
57	CARPET REPLACEMENT FOR A	2007	14,500	2,900	5	2,900		4,350	57
58	REPAIRS TO FIRE PUMP SYS	2007	4,571	653	7	653		980	58
59									59
60	TRANSFER SWITCHES	2008	34,753	2,482	7	4,965	2,482	2,482	60
61	WATER MAIN BREAK REPAIR	2008	3,607	180	10	361	180	180	61
62	ELEVATOR	2008	141,962	3,549	20	7,098	3,549	3,549	62
63	WATER MAIN BREAK (REPAIR)	2008	7,074	354	10	707	354	354	63
64	CAPITAL LEASE - COPIER	2008	23,856	2,396	5	4,791	2,396	2,396	64
65	DEPRECIATION FOR FIN 47 ASSETS	2008		22,042		22,042			65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 6,369,482	\$ 278,334		\$ 287,295	\$ 8,961	\$ 2,305,127	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: 01/01/08 Ending: 12/31/08

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	\$ 1,548,997	\$ 117,663	\$ 117,663	\$	11	\$ 734,249	71
72	Current Year Purchases	100,288	5,728	11,456	5,728	10	5,728	72
73	Fully Depreciated Assets	339,718				6	339,841	73
74	Home Office Allocation		96,175	96,175				74
75	TOTALS	\$ 1,989,003	\$ 219,566	\$ 225,294	\$ 5,728		\$ 1,079,818	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	\$ 36,125	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)		\$ 50,125	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)	\$ 9,070,817	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 502,150	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 515,898	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 13,748	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,435,070	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				24,984			5
6					_____			6
7	TOTAL				\$ 24,984			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.	_____ /2009	\$ _____
13.	_____ /2010	\$ _____
14.	_____ /2011	\$ _____

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: \$ _____ Description: Nursing \$52,717; Sup Liv \$555; Activities \$-9; Administration \$9,468; Home Office \$ 3,774

(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	\$	7,682	\$ 475,793	\$	7,682	\$ 475,793	1
2	Licensed Speech and Language Development Therapist	10a,3	hrs		1,306	81,746		1,306	81,746	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a,3	hrs		8,125	500,686		8,125	500,686	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				628,227		628,227	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$	17,113	\$ 1,058,225	\$ 628,227	17,113	\$ 1,686,452	14

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

Facility Name & ID Number Provena Cor Mariae Center # 0041046 Report Period Beginning: 01/01/08 Ending: 12/31/08

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/08 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 7,556,064	\$	1
2	Cash-Patient Deposits	112,800		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	14,518,279		3
4	Supply Inventory (priced at)	609,759		4
5	Short-Term Investments			5
6	Prepaid Insurance	22,320		6
7	Other Prepaid Expenses	150,561		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 22,969,783	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	6,624,013		12
13	Land	6,742,855		13
14	Buildings, at Historical Cost	84,767,866		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	18,707,364		16
17	Accumulated Depreciation (book methods)	(52,758,206)		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>	113,256		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 64,197,148	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 87,166,931	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 4,366,203	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,621,117		28
29	Short-Term Notes Payable	50,318		29
30	Accrued Salaries Payable	3,252,222		30
31	Accrued Taxes Payable (excluding real estate taxes)	103,086		31
32	Accrued Real Estate Taxes(Sch.IX-B)	935,960		32
33	Accrued Interest Payable	29,590		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Due to Related Party</u>	1,231,737		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 11,590,233	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,218,868		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	289,981		42
	Other Long-Term Liabilities(specify):			
43	<u>Conditional Asset Retirement</u>	438,744		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,947,593	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 13,537,826	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 73,629,105	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 87,166,931	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 73,253,756	1
2	Restatements (describe):		2
3	Transfer to Affiliates	(358,099)	3
4	Adj. To reconcile consolidated equity & consolidated income	45,247	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 72,940,904	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	248,788	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	683,319	11
12	Expenditures for Specific Purposes	(243,906)	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)	\$ 688,201	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)	\$ 73,629,105	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Provena Cor Mariae Center# 0041046Report Period Beginning: 01/01/08Ending: 12/31/08**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	\$ 7,522,651	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,522,651	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,711,695	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,711,695	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	620,029	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	762	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 620,791	23
D. Non-Operating Revenue			
24	Contributions	43,990	24
25	Interest and Other Investment Income***	9,768	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 53,758	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Purchase Rebates	290,131	28
28a	Misc Income & Gain/Loss SOFA	84,779	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 374,910	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,283,805	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,931,798	31
32	Health Care	4,437,978	32
33	General Administration	2,582,098	33
B. Capital Expense			
34	Ownership	414,839	34
C. Ancillary Expense			
35	Special Cost Centers	628,227	35
36	Provider Participation Fee	40,077	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,035,017	40
41	Income before Income Taxes (line 30 minus line 40)**	248,788	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 248,788	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No 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: 01/01/08

Ending:

12/31/08

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	1,680	1,834	\$ 81,957	\$ 44.69	1
2	Assistant Director of Nursing					2
3	Registered Nurses	20,184	21,590	712,127	32.98	3
4	Licensed Practical Nurses	23,141	26,146	682,520	26.10	4
5	CNAs & Orderlies	71,272	77,517	1,137,965	14.68	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,015	5,418	63,185	11.66	8
9	Activity Director	3,368	3,744	27,772	7.42	9
10	Activity Assistants	18,072	19,700	145,472	7.38	10
11	Social Service Workers	5,410	5,754	86,563	15.04	11
12	Dietician	1,825	2,080	50,061	24.07	12
13	Food Service Supervisor	3,464	3,685	48,290	13.10	13
14	Head Cook	4,914	5,531	66,896	12.09	14
15	Cook Helpers/Assistants	30,826	32,828	284,255	8.66	15
16	Dishwashers					16
17	Maintenance Workers	6,581	7,472	137,813	18.44	17
18	Housekeepers	16,454	17,458	159,579	9.14	18
19	Laundry	4,474	5,227	53,706	10.27	19
20	Administrator	1,940	2,080	107,227	51.55	20
21	Assistant Administrator	1,800	1,928	53,886	27.95	21
22	Other Administrative	5,049	5,424	115,249	21.25	22
23	Office Manager	1,924	2,080	36,102	17.36	23
24	Clerical	6,326	6,769	75,108	11.10	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</u>	2,008	2,080	44,883	21.58	33
34	TOTAL (lines 1 - 33)	235,727	256,345	\$ 4,170,616 *	\$ 16.27	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	304	\$ 20,202	1,3	35
36	Medical Director	\$1750/mo	21,000	9,3	36
37	Medical Records Consultant	28	2,058	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	40	3,147	11,3	44
45	Social Service Consultant	5	285	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	377	\$ 46,692		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	82	\$ 4,154	10,3	50
51	Licensed Practical Nurses	1,603	58,811	10,3	51
52	Certified Nurse Assistants/Aides	1,693	36,440	10,3	52
53	TOTAL (lines 50 - 52)	3,378	\$ 99,405		53

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Life Service Network \$6944
- (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. \$ 25,444 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. \$ 40,077
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.