

Facility Name & ID Number Provena St Anne Center# 0041731 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>120</u>	Skilled (SNF)	<u>120</u>	<u>43,920</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>59</u>	Intermediate (ICF)	<u>59</u>	<u>21,594</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>179</u>	TOTALS	<u>179</u>	<u>65,514</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>11,442</u>	<u>12,558</u>	<u>17,779</u>	<u>41,780</u>	8
9	SNF/PED					9
10	ICF	<u>8,423</u>	<u>6,765</u>		<u>15,187</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>19,865</u>	<u>19,323</u>	<u>17,779</u>	<u>56,967</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.95%

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

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

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

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

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

G. Do pages 3 & 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 10/06/1986

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

YES Date 10/06/1986 NO

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

YES NO If YES, enter number of beds certified 119 and days of care provided 17,779Medicare 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 St Anne Center # 0041731 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	490,138	73,485	43,019	606,642		606,642		606,642		1
2	Food Purchase		419,096		419,096		419,096	(85,214)	333,882		2
3	Housekeeping	168,989	26,205		195,194		195,194		195,194		3
4	Laundry	8,666	22,338	147,267	178,271		178,271		178,271		4
5	Heat and Other Utilities			252,410	252,410		252,410	4,805	257,215		5
6	Maintenance	142,370	40,025	53,370	235,765		235,765	52,154	287,919		6
7	Other (specify):* Pastoral Care	46,605	1,507	31,790	79,902		79,902	19,187	99,089		7
8	TOTAL General Services	856,768	582,656	527,856	1,967,280		1,967,280	(9,068)	1,958,212		8
	B. Health Care and Programs										
9	Medical Director			25,103	25,103		25,103		25,103		9
10	Nursing and Medical Records	4,667,022	380,242	253,610	5,300,874		5,300,874		5,300,874		10
10a	Therapy			1,484,246	1,484,246		1,484,246		1,484,246		10a
11	Activities	132,090	5,123	10,062	147,275		147,275	966	148,241		11
12	Social Services	112,690		345	113,035		113,035		113,035		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	4,911,802	385,365	1,773,366	7,070,533		7,070,533	966	7,071,499		16
	C. General Administration										
17	Administrative	444,097	49,895	1,361,280	1,855,272		1,855,272	(582,652)	1,272,620		17
18	Directors Fees										18
19	Professional Services			58,717	58,717		58,717	78,189	136,906		19
20	Dues, Fees, Subscriptions & Promotions			60,398	60,398		60,398	(16,038)	44,360		20
21	Clerical & General Office Expenses			128,763	128,763		128,763	14,048	142,811		21
22	Employee Benefits & Payroll Taxes			1,354,185	1,354,185		1,354,185	357,105	1,711,290		22
23	Inservice Training & Education			13,806	13,806		13,806	5,149	18,955		23
24	Travel and Seminar			18,417	18,417		18,417	10,530	28,947		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			143,979	143,979		143,979	731	144,710		26
27	Other (specify):* Bad Debt			4,514	4,514		4,514	(4,514)			27
28	TOTAL General Administration	444,097	49,895	3,144,059	3,638,051		3,638,051	(137,452)	3,500,599		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,212,667	1,017,916	5,445,281	12,675,864		12,675,864	(145,554)	12,530,310		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 Anne Center #0041731 Report Period Beginning: 01/01/08 Ending: 12/31/08

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			375,302	375,302	375,302	155,536	530,838				30
31	Amortization of Pre-Op. & Org.											31
32	Interest						1,123,170	1,123,170				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds						32,467	32,467				34
35	Rent-Equipment & Vehicles			25,122	25,122	25,122	4,904	30,026				35
36	Other (specify):*											36
37	TOTAL Ownership			400,424	400,424	400,424	1,316,077	1,716,501				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			1,287,565	1,287,565	1,287,565	(489,313)	798,252				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			98,271	98,271	98,271		98,271				42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			1,385,836	1,385,836	1,385,836	(489,313)	896,523				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,212,667	1,017,916	7,231,541	14,462,124	14,462,124	681,210	15,143,334				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 Anne Center

0041731

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	(89,961)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	18,067	30		9
10	Interest and Other Investment Income	(10,968)	32		10
11	Discounts, Allowances, Rebates & Refunds	(489,313)	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	(4,514)	27		24
25	Fund Raising, Advertising and Promotional	(28,092)	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)	\$ (604,781)		\$	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)	1,266,804		34
35	Other- Attach Schedule	19,187		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 1,285,991		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ 681,210		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			X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY						
48		49		50		51
						52

Provena St Anne Center

ID# 0041731

Report Period Beginning: 01/01/08

Ending: 12/31/08

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Development - Supplies	\$ 14	7	1
2	Development - Misc	19,173	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	Total	19,187		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Provena St Anne Center

0041731

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	(89,961)	4,747	0	0	0	0	0	0	0	0	0	(85,214)	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	4,805	0	0	0	0	0	0	0	0	0	4,805	5
6	Maintenance	0	2,187	0	49,967	0	0	0	0	0	0	0	52,154	6
7	Other (specify):*	19,187	0	0	0	0	0	0	0	0	0	0	19,187	7
8	TOTAL General Services	(70,774)	11,739	0	49,967	0	(9,068)	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	966	0	0	0	0	0	0	0	0	0	966	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	966	0	0	0	0	0	0	0	0	0	966	16
	C. General Administration													
17	Administrative	0	(542,783)	0	(39,869)	0	0	0	0	0	0	0	(582,652)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	50,578	0	27,611	0	0	0	0	0	0	0	78,189	19
20	Fees, Subscriptions & Promotions	(28,092)	12,054	0	0	0	0	0	0	0	0	0	(16,038)	20
21	Clerical & General Office Expenses	0	14,048	0	0	0	0	0	0	0	0	0	14,048	21
22	Employee Benefits & Payroll Taxes	0	90,042	0	267,063	0	0	0	0	0	0	0	357,105	22
23	Inservice Training & Education	0	5,149	0	0	0	0	0	0	0	0	0	5,149	23
24	Travel and Seminar	0	10,530	0	0	0	0	0	0	0	0	0	10,530	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	731	0	0	0	0	0	0	0	0	0	731	26
27	Other (specify):*	(4,514)	0	0	0	0	0	0	0	0	0	0	(4,514)	27
28	TOTAL General Administration	(32,606)	(359,651)	0	254,805	0	(137,452)	28						
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(103,380)	(346,946)	0	304,772	0	(145,554)	29						

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Provena St Anne Center

0041731

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	18,067	0	0	137,469	0	0	0	0	0	0	0	155,536	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(10,968)	0	0	1,134,138	0	0	0	0	0	0	0	1,123,170	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	32,467	0	0	0	0	0	0	0	32,467	34
35	Rent-Equipment & Vehicles	0	0	0	4,904	0	0	0	0	0	0	0	4,904	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	7,099	0	0	1,308,978	0	1,316,077	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	(489,313)	0	0	0	0	0	0	0	0	0	0	(489,313)	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	(489,313)	0	0	0	0	0	0	0	0	0	0	(489,313)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(585,594)	(346,946)	0	1,613,750	0	681,210	45						

Facility Name & ID Number Provena St Anne Center

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Report Period Beginning:

01/01/08

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%	\$ 4,747	\$ 4,747 1
2	V	5 Utilities		Provena Senior Services	100.00%	4,805	4,805 2
3	V	6 Maintenance - Other		Provena Senior Services	100.00%	2,187	2,187 3
4	V	11 Activities-Special Events		Provena Senior Services	100.00%	966	966 4
5	V	17 Admin - Misc. Other	854,400	Provena Senior Services	100.00%	(2,596)	(856,996) 5
6	V	17 Administrative Salaries		Provena Senior Services	100.00%	314,213	314,213 6
7	V	19 Professional Services		Provena Senior Services	100.00%	50,578	50,578 7
8	V	20 Dues,Subscriptions		Provena Senior Services	100.00%	12,054	12,054 8
9	V	21 Clerical Supplies		Provena Senior Services	100.00%	14,048	14,048 9
10	V	22 Employee Benefits		Provena Senior Services	100.00%	90,042	90,042 10
11	V	23 Education/Conference		Provena Senior Services	100.00%	5,149	5,149 11
12	V	24 Travel		Provena Senior Services	100.00%	10,530	10,530 12
13	V	26 Insurance		Provena Senior Services	100.00%	731	731 13
14	Total		\$ 854,400			\$ 507,454	\$ * (346,946) 14

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

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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%	\$ 4,744	\$ 4,744	15
16	V	32 Interest		Provena Senior Services	100.00%	411,337	411,337	16
17	V	34 Rent - Facility		Provena Senior Services	100.00%	32,467	32,467	17
18	V	35 Rent - Equipment		Provena Senior Services	100.00%	4,904	4,904	18
19	V	17 Admin Salaries	199,080	Provena Health Services	100.00%	124,060	(75,020)	19
20	V	22 Employee Benefits		Provena Health Services	100.00%	94,412	94,412	20
21	V	30 Depreciation		Provena Health Services	100.00%	132,725	132,725	21
22	V	19 Admin Consulting,Other		Provena Health Services	100.00%	27,611	27,611	22
23	V	17 Information Systems Salaries	307,800	Provena Health Services	100.00%	215,361	(92,439)	23
24	V	22 Information Systems Benefits		Provena Health Services	100.00%	57,099	57,099	24
25	V	17 Information Systems - Other		Provena Health Services	100.00%	29,119	29,119	25
26	V	17 Admin Salaries		Provena Health Services	100.00%	39,946	39,946	26
27	V	22 Employee Benefits		Provena Health Services	100.00%	63,066	63,066	27
28	V	17 Information Systems Salaries		Provena Health Services	100.00%	58,525	58,525	28
29	V	22 Information Systems Benefits		Provena Health Services	100.00%	52,486	52,486	29
30	V	6 Information Systems - Equip Maint		Provena Health Services	100.00%	49,967	49,967	30
31	V	32 Admin - Interest Expense		Provena Health Services	100.00%	722,801	722,801	31
32	V	39 Ancillary Services - Other	1,287,565	Provena Senior Services Pharmacy	100.00%	1,287,565		32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 1,794,445			\$ 3,408,195	\$ * 1,613,750	39

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

Facility Name & ID Number

Provena St Anne Center

#

0041731

Report Period Beginning:

01/01/08

Ending:

12/31/08

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 Anne Center

0041731

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	\$	854,400	\$ 4,747	1
2	5	Utilities	Management Fee Income 6,616,778	19	37,212		854,400	4,805	2
3	6	Maintenance - Other	Management Fee Income 6,616,778	19	16,939		854,400	2,187	3
4	11	Activities-Special Events	Management Fee Income 6,616,778	19	7,482		854,400	966	4
5	17	Admin - Misc. Other	Management Fee Income 6,616,778	19	(20,102)		854,400	(2,596)	5
6	17	Administrative Salaries	Management Fee Income 6,616,778	19	2,433,377	2,433,377	854,400	314,213	6
7	19	Professional Services	Management Fee Income 6,616,778	19	391,693		854,400	50,578	7
8	20	Dues,Subscriptions	Management Fee Income 6,616,778	19	93,352		854,400	12,054	8
9	21	Clerical Supplies	Management Fee Income 6,616,778	19	108,789		854,400	14,048	9
10	22	Employee Benefits	Management Fee Income 6,616,778	19	697,316		854,400	90,042	10
11	23	Education/Conference	Management Fee Income 6,616,778	19	39,879		854,400	5,149	11
12	24	Travel	Management Fee Income 6,616,778	19	81,549		854,400	10,530	12
13	26	Insurance	Management Fee Income 6,616,778	19	5,664		854,400	731	13
14	30	Depreciation	Management Fee Income 6,616,778	19	36,741		854,400	4,744	14
15	32	Interest	Management Fee Income 6,616,778	19	3,185,539		854,400	411,337	15
16	34	Rent - Facility	Management Fee Income 6,616,778	19	251,434		854,400	32,467	16
17	35	Rent - Equipment	Management Fee Income 6,616,778	19	37,982		854,400	4,904	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 7,441,612	\$ 2,433,377		\$ 960,906	25

Facility Name & ID Number Provena St Anne Center

0041731

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	199,080	\$ 124,060	1
2	22	Employee Benefits	Operating Expense	1,391,394	9	659,854		199,080	94,412	2
3	30	Depreciation	Operating Expense	1,391,394	9	927,633		199,080	132,725	3
4	34	Rent Facility	Operating Expense	1,391,394	9	192,975		199,080	27,611	4
5	19	Admin Consulting,Other	Operating Expense	1,391,394	9	1,505,183		199,080	215,361	5
6	17	Information Systems Salaries	Operating Expense	2,155,920	9	399,935	399,935	307,800	57,099	6
7	22	Information Systems Benefits	Operating Expense	2,155,920	9	203,956		307,800	29,119	7
8	17	Information Systems - Other	Operating Expense	2,155,920	9	279,796		307,800	39,946	8
9	17	Admin Salaries	Direct Cost	1,391,394	9	440,776	440,776	199,080	63,066	9
10	17	Information Systems Salaries	Direct Cost	2,155,920	9	409,925	409,925	307,800	58,525	10
11	6	Information Systems - Equip Main	Direct Cost	2,155,920	9	367,627		307,800	52,486	11
12	19	Admin Consulting,Other	Direct Cost	1,391,394	9	349,224		199,080	49,967	12
13	32	Admin - Interest Expense	Direct Cost	1,391,394	9	5,051,741		199,080	722,801	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		\$ 1,667,178	25

Facility Name & ID Number Provena St Anne Center

0041731

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		\$	\$		\$ 1,287,565	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				\$	\$		\$ 1,287,565	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									\$ 411,337	1									
2											2									
3											3									
4											4									
5											5									
Working Capital																				
6											6									
7											7									
8											8									
9	TOTAL Facility Related					\$	\$			\$ 411,337	9									
B. Non-Facility Related*																				
10											10									
11											11									
12											12									
13											13									
14	TOTAL Non-Facility Related					\$	\$			\$	14									
15	TOTALS (line 9+line14)					\$	\$			\$ 411,337	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 St Anne Center COUNTY Winnebago

FACILITY IDPH LICENSE NUMBER 0041731

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE (____) _____ FAX #: (____) _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 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. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 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 St Anne Center

0041731 Report Period Beginning:

01/01/08 Ending:

12/31/08

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 70,000 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).

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>1985</u>	<u>\$ 639,976</u>	1
2					2
3	TOTALS			\$ 639,976	3

Facility Name & ID Number Provena St Anne Center

0041731

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	120		1986	1986	\$ 3,516,907	\$ 100,483	35	\$ 100,483		\$ 2,339,247	4
5	59		1993	1993	2,722,251	90,742	30	90,742		1,398,188	5
6											6
7											7
8											8
Improvement Type**											
9			1990		34,784	1,122	31	1,122		20,758	9
10	Various		1991		3,839		10			3,839	10
11	Various		1992		471		10			471	11
12	Various		1993		3,828		10			3,828	12
13	Various		1994		5,000		10			5,000	13
14	Various		1995		40,225	1,271	18	1,271		24,550	14
15	Various		1996		28,449	1,427	12	1,427		23,989	15
16	Various		1997		24,289		5			24,289	16
17	Various		1998		25,080		5			25,080	17
18	Various		1999		6,269	60	5	60		6,239	18
19	Various		2000		27,288	571	5	571		26,432	19
20	Various		2001		283,276	18,653	6	18,653		172,872	20
21	Various		2002		13,716	950	10	950		9,498	21
22	Various		2003		34,755	3,196	9	3,196		18,163	22
23	Various		2004		40,348	4,412	8	4,412		21,703	23
24	Various										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 St Anne Center

0041731

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	GENERATOR- FLUSH COOLING SYSTEM,SEAL	2005	\$ 3,112	\$ 622	5	\$ 622	\$	\$ 2,490	37
38	WATER HEATER ON LOWER LEVEL	2005	5,330	533	10	533		2,132	38
39	H/M DOORS AND FRAMES	2005	1,481	74	20	74		259	39
40	DEMOLITION & DRYWALL	2005	2,841	284	10	284		994	40
41	REPLACE AIR COMPRESSOR	2005	1,984	165	12	165		579	41
42	REPLACE RADIATOR BELTS / FLUSH AND R	2005	1,200	240	5	240		960	42
43	REPLACE BREATHER, HOSES, AMPMETER, A	2005	1,462	209	7	209		731	43
44	V14 SOLAR PROTECTIVE FILM APPLIED TO	2005	598	120	5	120		418	44
45	3 CRANK HURD WINDOWS	2005	5,745	575	10	575		2,011	45
46	DOOR CLOSURES	2005	1,772	177	10	177		620	46
47	4'X6' ALUMINUM FRAMED MAGNETIC WHITE	2005	785	79	10	79		275	47
48	V14 SOLAR PROTECTIVE FIL 15 PANES BLUE	2005	582	58	10	58		204	48
49									49
50									50
51									51
52	PLUMBING FOR NEW BREAK ROOM SINK	2006	2,950	148	20	148		443	52
53	ELECTRICAL FOR NEW KITCHENETTE AND F	2006	4,279	285	15	285		856	53
54	REPLACE ROOF MOUNT MUA UNIT	2006	9,935	662	15	662		1,987	54
55	HOLLOW METAL FRAMES AND DOORS	2006	585	29	20	29		73	55
56	REPLACE PIPING	2006	1,359	91	15	91		227	56
57	OPEN CEILING FOR SPRINKLER REPAIR AN	2006	1,000	200	5	200		500	57
58	VINYL SIDING ON GARAGE AND SEAMLESS	2006	4,365	291	15	291		728	58
59	V14 SOLAR PROTECTIVE FIM APPLIED TO	2006	555	111	5	111		333	59
60	RUB RAILS	2006	2,051	205	10	205		513	60
61	WALK IN COOLER AND FREEZER / ROOFTOP	2006	30,100	2,007	15	2,007		5,017	61
62	TEKNOFLOR/VINYL BASE IN MAIN DINING	2006	22,100	2,210	10	2,210		5,525	62
63	TILE IN 8 PATIENT ROOMS	2006	7,640	1,528	5	1,528		3,820	63
64	REPLACE CEILING TILES IN MAIN DINING	2006	4,000	400	10	400		1,000	64
65	REMOVE & REPAIR WATER DAMAGE AT SKY	2006	4,730	473	10	473		1,183	65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 6,933,316	\$ 234,662		\$ 234,662	\$	\$ 4,158,021	70

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

Facility Name & ID Number Provena St Anne Center

0041731

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	
1	Totals from Page 12A, Carried Forward		\$ 6,933,316	\$ 234,662		\$ 234,662	\$	\$ 4,158,021	1
2									2
3	<u>PAINING ROOMS AND HALLWAYS</u>	2007	9,922	1,984	5	1,984		3,969	3
4	<u>REMODEL OF MAIN NURSES STATION</u>	2007	12,500	833	15	833		1,250	4
5	<u>INSTALL ACOUSTICAL CEILINF & TILE FO</u>	2007	36,500	3,650	10	3,650		5,475	5
6	<u>ELECTRICAL WORK</u>	2007	9,609	961	10	961		1,441	6
7	<u>(19) SUPPLY/RETURN GRILLES INTO NEW</u>	2007	3,280	469	7	469		703	7
8	<u>10 TON ROOFTOP UNIT WITH GAS HEAT,EC</u>	2007	11,889	793	15	793		1,189	8
9	<u>SPRINKLER SYSTEM / CONCRETE</u>	2007	750	30	25	30		45	9
10	<u>CABINETS AND COUNTERTOPS</u>	2007	12,516	834	15	834		1,252	10
11	<u>REPLACE FIRE SPRINKLER MAINS</u>	2007	66,669	6,667	10	6,667		9,866	11
12	<u>VINYL FLOORING & CARPET FOR LOBBY</u>	2007	7,886	789	10	789		1,207	12
13									13
14	<u>BUILD 25 UNITS (ROOM DIVIDERS)</u>	2008	19,250	1,925	10	3,850	1,925	1,925	14
15	<u>VOICE ANNOUNCEMENT UNIT</u>	2008	4,530	453	10	906	453	453	15
16	<u>ECO FRIENDLY GREEN HOUSE</u>	2008	475	10	25	19	10	10	16
17	<u>ELECTRICAL FOR KITCHEN EQUIP IN NEW</u>	2008	6,376	425	15	850	425	425	17
18	<u>ROOF REPAIRS</u>	2008	29,859	1,493	10	2,986	1,493	1,493	18
19	<u>CAFE REMODEL</u>	2008	765	38	10	77	38	38	19
20	<u>MCQUAY PTAC UNITS</u>	2008	10,900	363	15	727	363	363	20
21	<u>STAIN EXTERIOR BOARD AND TRIM</u>	2008	3,650	261	7	521	261	261	21
22	<u>(11) THERMO WINDOWS</u>	2008	7,700	193	20	385	193	193	22
23	<u>NURSE CALL SYSTEM</u>	2008	61,170	3,059	10	6,117	3,059	3,059	23
24	<u>FIRE DAMPERS</u>	2008	4,101	205	10	410	205	205	24
25	<u>CARESENSE CHAIR MONITORING SYSTEM/BE</u>	2008	9,706	485	10	971	485	485	25
26	<u>SEALCOATING OF PARKING LOT</u>	2008	2,781	174	8	348	174	174	26
27	<u>INSTALLATION OF 10 AND SERVICE TO EX</u>	2008	6,920	346	10	692	346	346	27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,273,021	\$ 261,101		\$ 270,530	\$ 9,429	\$ 4,193,846	34

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

Facility Name & ID Number Provena St Anne Center # 0041731 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	\$ 1,022,966	\$ 105,564	\$ 105,564	\$	10	\$ 350,410	71
72	Current Year Purchases	127,386	8,638	17,275	8,638	11	8,638	72
73	Fully Depreciated Assets	376,593				7	370,255	73
74	Home Office Allocation		137,469	137,469				74
75	TOTALS	\$ 1,526,945	\$ 251,671	\$ 260,308	\$ 8,638		\$ 729,302	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	1998 Minivan	1998	\$ 43,500	\$	\$	\$	5	\$	76
77	Plant Engineering	1999 F150 Ford Truck	1999	23,172				3		77
78										78
79										79
80	TOTALS			\$ 66,672	\$	\$	\$		\$	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)	\$ 9,506,613	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 512,772	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 530,838	83**
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 18,067	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,923,149	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.

Facility Name & ID Number Provena St Anne Center

0041731

Report Period Beginning: 01/01/08

Ending: 12/31/08

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				32,467			5
6					_____			6
7	TOTAL				\$ 32,467			7

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: \$ 273,503 Description: Nursing \$235,660; Activities \$41; Plant \$7,947; Pastoral \$53; Admin \$24,898; Home Office \$4,904

(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

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	\$ _____

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

Facility Name & ID Number Provena St Anne Center# 0041731 Report Period Beginning:01/01/08 Ending:12/31/08

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	\$	10,803	\$ 669,110	\$	10,803	\$ 669,110	1
2	Licensed Speech and Language Development Therapist	10a,3	hrs		1,217	76,156		1,217	76,156	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a,3	hrs		11,993	738,980		11,993	738,980	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				1,287,565		1,287,565	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			\$	24,013	\$ 1,484,246	\$ 1,287,565	24,013	\$ 2,771,811	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 Anne Center# 0041731Report 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	2	
		Operating	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	2	
		Operating	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	(258,520)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 72,637,137	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	552,555	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)	\$ 991,968	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 St Anne Center

0041731

Report Period Beginning: 01/01/08

Ending: 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	\$ 10,684,697	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 10,684,697	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,331,094	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,331,094	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	88,292	12
13	Barber and Beauty Care	4,047	13
14	Non-Patient Meals	1,669	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,254,566	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	11,689	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,360,263	23
D. Non-Operating Revenue			
24	Contributions	47,365	24
25	Interest and Other Investment Income***	10,968	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 58,333	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Purchase Rebates	489,313	28
28a	Misc Income & Gain/Loss SOFA	90,979	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 580,292	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 15,014,679	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,967,280	31
32	Health Care	7,070,533	32
33	General Administration	3,638,051	33
B. Capital Expense			
34	Ownership	400,424	34
C. Ancillary Expense			
35	Special Cost Centers	1,287,565	35
36	Provider Participation Fee	98,271	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 14,462,124	40
41	Income before Income Taxes (line 30 minus line 40)**	552,555	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 552,555	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 St Anne Center

0041731

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	1,912	2,080	\$ 79,851	\$ 38.39	1
2	Assistant Director of Nursing	1,256	1,360	46,483	34.18	2
3	Registered Nurses	23,756	25,372	750,321	29.57	3
4	Licensed Practical Nurses	67,746	73,049	1,769,368	24.22	4
5	CNAs & Orderlies	138,458	149,365	1,924,420	12.88	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,725	8,192	96,580	11.79	8
9	Activity Director	1,960	2,080	37,671	18.11	9
10	Activity Assistants	7,842	8,622	94,418	10.95	10
11	Social Service Workers	6,310	6,816	112,690	16.53	11
12	Dietician	1,912	2,080	45,238	21.75	12
13	Food Service Supervisor	4,058	4,339	78,601	18.12	13
14	Head Cook	10,646	11,264	113,657	10.09	14
15	Cook Helpers/Assistants	26,235	27,662	252,642	9.13	15
16	Dishwashers					16
17	Maintenance Workers	7,658	8,304	142,370	17.14	17
18	Housekeepers	17,407	18,780	168,989	9.00	18
19	Laundry	1,050	1,074	8,666	8.07	19
20	Administrator	1,828	2,080	98,555	47.38	20
21	Assistant Administrator	1,560	1,736	46,749	26.93	21
22	Other Administrative	6,500	6,832	161,231	23.60	22
23	Office Manager	1,840	2,080	42,548	20.46	23
24	Clerical	6,508	7,149	95,015	13.29	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>	2,149	2,429	46,604	19.19	33
34	TOTAL (lines 1 - 33)	346,316	372,745	\$ 6,212,667 *	\$ 16.67	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	649	\$ 41,565	1,3	35
36	Medical Director	\$1750/mo	22,450	9,3	36
37	Medical Records Consultant	10	709	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	49	3,393	11,3	44
45	Social Service Consultant	6	345	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	714	\$ 68,462		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses				50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

Facility Name & ID Number Provena St Anne Center

0041731

Report Period Beginning: 01/01/08

Ending: 12/31/08

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	
Janelle Chadwick	Administrator	0	\$ 98,555	Workers' Compensation Insurance	\$ 181,320	IDPH License Fee	\$	
Administrative Staff	Asst Administrator	0	46,749	Unemployment Compensation Insurance	14,935	Advertising: Employee Recruitment		
Administrative Staff	Office Manager	0	42,548	FICA Taxes	443,707	Health Care Worker Background Check		
Administrative Staff	Human Resources	0	38,744	Employee Health Insurance	494,602	(Indicate # of checks performed <u>97</u>)		
Administrative Staff	Receptionist	0	58,499	Employee Meals		Patient Background Checks	<u>559</u>	
Administrative Staff	Admin Asst	0	36,516	Illinois Municipal Retirement Fund (IMRF)*		Employee Recruitment	17,947	
Administrative Staff	Admissions	0	122,486	Life Insurance	29,771	Dues & Subscription	10,379	
TOTAL (agree to Schedule V, line 17, col. 1)				Pension	160,685	Advertising & Public Relations	32,072	
(List each licensed administrator separately.)			\$ 444,097	Employee Recognition	7,540			
B. Administrative - Other				Executive Benefits	7,418	Home Office Allocation	12,054	
Description			Amount	Employee Screening	14,207	Less: Public Relations Expense	()	
Corp Service Fee			\$ 199,080	Home Office Allocation	357,105	Non-allowable advertising	(28,092)	
Corp Service IS Fee			307,800			Yellow page advertising	()	
Mgmt Fee			615,960	TOTAL (agree to Schedule V, line 22, col.8)			\$ 1,711,290	
Mgmt Fee Interest			238,440	E. Schedule of Non-Cash Compensation Paid to Owners or Employees				
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 1,361,280	Description	Line #	Amount		
(Attach a copy of any management service agreement)				N/A		\$		
C. Professional Services				G. Schedule of Travel and Seminar**				
Vendor/Payee	Type		Amount	Description			Amount	
Legal Expense	Various		\$ 38,178	Out-of-State Travel			\$ 1,355	
Survey & Analytical Tools	Various		9,866					
Transportation Service	Various		6,400	In-State Travel			17,062	
Gift Shop	Various		1,200					
Shredding/Storage	Various		1,097	Seminar Expense				
Living Design	Various			Home Office Allocation			10,530	
Outsourced Services	Various		1,976	Entertainment Expense			()	
				(agree to Sch. V, line 24, col. 8)				
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			\$ 28,947	
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 58,717					

* 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 \$8577
- (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? 179
- (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. \$ 74,331 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. \$ 98,271
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. \$ 1,669
- (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.