

Facility Name & ID Number Provena St Joseph Center

0041871 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	120	Skilled (SNF)	120	43,920	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	120	TOTALS	120	43,920	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	19,573	11,309	4,825	35,707	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	19,573	11,309	4,825	35,707	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.30%

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

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

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

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

N/A - None

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

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

YES NO

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

YES NO

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

Date started 7/1/1996

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

YES Date 7/1/1996 NO

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

YES NO If YES, enter number of beds certified 120 and days of care provided 4,825

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 St Joseph Center # 0041871 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	429,306	29,981	13,698	472,985		472,985		472,985		1
2	Food Purchase		182,127		182,127		182,127	(43,041)	139,086		2
3	Housekeeping	157,283	24,672		181,955		181,955		181,955		3
4	Laundry		2,829	101,185	104,014		104,014		104,014		4
5	Heat and Other Utilities			334,545	334,545		334,545	2,504	337,049		5
6	Maintenance	101,134	28,538	80,960	210,632		210,632	25,355	235,987		6
7	Other (specify):* Pastoral Care	46,900	1,685	66,055	114,640		114,640	66,572	181,212		7
8	TOTAL General Services	734,623	269,832	596,443	1,600,898		1,600,898	51,390	1,652,288		8
	B. Health Care and Programs										
9	Medical Director			12,000	12,000		12,000		12,000		9
10	Nursing and Medical Records	2,096,520	133,945	67,088	2,297,553		2,297,553		2,297,553		10
10a	Therapy			514,829	514,829		514,829		514,829		10a
11	Activities	90,896	779	2,544	94,219		94,219	504	94,723		11
12	Social Services	22,809		1,035	23,844		23,844		23,844		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,210,225	134,724	597,496	2,942,445		2,942,445	504	2,942,949		16
	C. General Administration										
17	Administrative	250,133	24,052	691,560	965,745		965,745	(302,571)	663,174		17
18	Directors Fees										18
19	Professional Services			29,005	29,005		29,005	39,743	68,748		19
20	Dues, Fees, Subscriptions & Promotions			50,588	50,588		50,588	(25,209)	25,379		20
21	Clerical & General Office Expenses			77,659	77,659		77,659	7,322	84,981		21
22	Employee Benefits & Payroll Taxes			874,790	874,790		874,790	176,568	1,051,358		22
23	Inservice Training & Education			8,676	8,676		8,676	2,684	11,360		23
24	Travel and Seminar			8,780	8,780		8,780	5,488	14,268		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			83,160	83,160		83,160	381	83,541		26
27	Other (specify):* Bad Debt			19,056	19,056		19,056	(19,056)			27
28	TOTAL General Administration	250,133	24,052	1,843,274	2,117,459		2,117,459	(114,650)	2,002,809		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,194,981	428,608	3,037,213	6,660,802		6,660,802	(62,756)	6,598,046		29

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

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

Facility Name & ID Number Provena St Joseph Center #0041871 Report Period Beginning: 01/01/08 Ending: 12/31/08

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			240,493	240,493	240,493	85,978	326,471				30
31	Amortization of Pre-Op. & Org.											31
32	Interest						563,751	563,751				32
33	Real Estate Taxes			104,040	104,040	104,040		104,040				33
34	Rent-Facility & Grounds						16,922	16,922				34
35	Rent-Equipment & Vehicles			9,163	9,163	9,163	2,556	11,719				35
36	Other (specify):*											36
37	TOTAL Ownership			353,696	353,696	353,696	669,207	1,022,903				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			338,221	338,221	338,221	(216,827)	121,394				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			65,880	65,880	65,880		65,880				42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			404,101	404,101	404,101	(216,827)	187,274				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,194,981	428,608	3,795,010	7,418,599	7,418,599	389,624	7,808,223				45

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

Facility Name & ID Number Provena St Joseph Center

0041871

Report Period Beginning: 01/01/08

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	(45,515)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	19,182	30		9
10	Interest and Other Investment Income	(931)	32		10
11	Discounts, Allowances, Rebates & Refunds	(216,827)	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	(19,056)	27		24
25	Fund Raising, Advertising and Promotional	(31,492)	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)	\$ (294,639)		\$	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)	617,691		34
35	Other- Attach Schedule	66,572		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 684,263		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ 389,624		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. (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 Joseph Center

ID# 0041871

Report Period Beginning: 01/01/08

Ending: 12/31/08

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Development - Office Supplies	\$ 661	7	1
2	Development - Misc	65,911	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	66,572		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Provena St Joseph Center

0041871

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	(45,515)	2,474	0	0	0	0	0	0	0	0	0	(43,041)	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	2,504	0	0	0	0	0	0	0	0	0	2,504	5
6	Maintenance	0	1,140	24,215	0	0	0	0	0	0	0	0	25,355	6
7	Other (specify):*	66,572	0	0	0	0	0	0	0	0	0	0	66,572	7
8	TOTAL General Services	21,057	6,118	24,215	0	51,390	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	504	0	0	0	0	0	0	0	0	0	504	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	504	0	0	0	0	0	0	0	0	0	504	16
	C. General Administration													
17	Administrative	0	(282,903)	(19,668)	0	0	0	0	0	0	0	0	(302,571)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	26,362	13,381	0	0	0	0	0	0	0	0	39,743	19
20	Fees, Subscriptions & Promotions	(31,492)	6,283	0	0	0	0	0	0	0	0	0	(25,209)	20
21	Clerical & General Office Expenses	0	7,322	0	0	0	0	0	0	0	0	0	7,322	21
22	Employee Benefits & Payroll Taxes	0	46,931	129,637	0	0	0	0	0	0	0	0	176,568	22
23	Inservice Training & Education	0	2,684	0	0	0	0	0	0	0	0	0	2,684	23
24	Travel and Seminar	0	5,488	0	0	0	0	0	0	0	0	0	5,488	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	381	0	0	0	0	0	0	0	0	0	381	26
27	Other (specify):*	(19,056)	0	0	0	0	0	0	0	0	0	0	(19,056)	27
28	TOTAL General Administration	(50,548)	(187,452)	123,350	0	(114,650)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(29,491)	(180,830)	147,565	0	(62,756)	29							

STATE OF ILLINOIS

Facility Name & ID Number Provena St Joseph Center

0041871

Report Period Beginning:

01/01/08 Ending:

Summary B

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	19,182	0	66,796	0	0	0	0	0	0	0	0	85,978	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(931)	0	564,682	0	0	0	0	0	0	0	0	563,751	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	16,922	0	0	0	0	0	0	0	0	16,922	34
35	Rent-Equipment & Vehicles	0	0	2,556	0	0	0	0	0	0	0	0	2,556	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	18,251	0	650,956	0	669,207	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	(216,827)	0	0	0	0	0	0	0	0	0	0	(216,827)	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	(216,827)	0	0	0	0	0	0	0	0	0	0	(216,827)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(228,067)	(180,830)	798,521	0	389,624	45							

Facility Name & ID Number Provena St Joseph Center

0041871

Report Period Beginning:

01/01/08

Ending:

12/31/08

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%	\$ 2,474	\$ 2,474 1
2	V	5 Utilities		Provena Senior Services	100.00%	2,504	2,504 2
3	V	6 Maintenance - Other		Provena Senior Services	100.00%	1,140	1,140 3
4	V	11 Activities-Special Events		Provena Senior Services	100.00%	504	504 4
5	V	17 Admin - Misc. Other	445,320	Provena Senior Services	100.00%	(1,353)	(446,673) 5
6	V	17 Administrative Services		Provena Senior Services	100.00%	163,770	163,770 6
7	V	19 Professional Salaries		Provena Senior Services	100.00%	26,362	26,362 7
8	V	20 Dues,Subscriptions		Provena Senior Services	100.00%	6,283	6,283 8
9	V	21 Clerical Supplies		Provena Senior Services	100.00%	7,322	7,322 9
10	V	22 Employee Benefits		Provena Senior Services	100.00%	46,931	46,931 10
11	V	23 Education/Conference		Provena Senior Services	100.00%	2,684	2,684 11
12	V	24 Travel		Provena Senior Services	100.00%	5,488	5,488 12
13	V	26 Insurance		Provena Senior Services	100.00%	381	381 13
14	Total		\$ 445,320			\$ 264,490	\$ * (180,830) 14

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

Facility Name & ID Number Provena St Joseph Center# 0041871Report Period Beginning: 01/01/08Ending: 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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	30 Depreciation	\$	Provena Senior Services	100.00%	\$ 2,473	\$ 2,473	15
16	V	32 Interest		Provena Senior Services	100.00%	214,392	214,392	16
17	V	34 Rent - Facility		Provena Senior Services	100.00%	16,922	16,922	17
18	V	35 Rent - Equipment		Provena Senior Services	100.00%	2,556	2,556	18
19	V	17 Admin Salaries	96,480	Provena Health Services	100.00%	60,123	(36,357)	19
20	V	22 Employee Benefits		Provena Health Services	100.00%	45,755	45,755	20
21	V	30 Depreciation		Provena Health Services	100.00%	64,323	64,323	21
22	V	19 Admin Consulting,Other		Provena Health Services	100.00%	13,381	13,381	22
23	V	17 Information Systems Salaries	149,760	Provena Health Services	100.00%	104,370	(45,390)	23
24	V	22 Information Systems Benefits		Provena Health Services	100.00%	27,781	27,781	24
25	V	17 Information Systems - Other		Provena Health Services	100.00%	14,168	14,168	25
26	V	17 Admin Salaries		Provena Health Services	100.00%	19,436	19,436	26
27	V	22 Employee Benefits		Provena Health Services	100.00%	30,564	30,564	27
28	V	17 Information Systems Salaries		Provena Health Services	100.00%	28,475	28,475	28
29	V	22 Information Systems Benefits		Provena Health Services	100.00%	25,537	25,537	29
30	V	6 Information Systems - Equip Maint		Provena Health Services	100.00%	24,215	24,215	30
31	V	32 Admin - Interest Expense		Provena Health Services	100.00%	350,290	350,290	31
32	V	39 Ancillary Services - Other	338,221	Provena Senior Services Pharmacy	100.00%	338,221		32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 584,461			\$ 1,382,982	\$ * 798,521	39

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

Facility Name & ID Number Provena St Joseph Center # 0041871 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 Joseph Center

0041871

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	\$	445,320	\$ 2,474	1
2	5	Utilities	Management Fee Income 6,616,778	19	37,212		445,320	2,504	2
3	6	Maintenance - Other	Management Fee Income 6,616,778	19	16,939		445,320	1,140	3
4	11	Activities-Special Events	Management Fee Income 6,616,778	19	7,482		445,320	504	4
5	17	Admin - Misc. Other	Management Fee Income 6,616,778	19	(20,102)		445,320	(1,353)	5
6	17	Administrative Salaries	Management Fee Income 6,616,778	19	2,433,377	2,433,377	445,320	163,770	6
7	19	Professional Services	Management Fee Income 6,616,778	19	391,693		445,320	26,362	7
8	20	Dues,Subscriptions	Management Fee Income 6,616,778	19	93,352		445,320	6,283	8
9	21	Clerical Supplies	Management Fee Income 6,616,778	19	108,789		445,320	7,322	9
10	22	Employee Benefits	Management Fee Income 6,616,778	19	697,316		445,320	46,931	10
11	23	Education/Conference	Management Fee Income 6,616,778	19	39,879		445,320	2,684	11
12	24	Travel	Management Fee Income 6,616,778	19	81,549		445,320	5,488	12
13	26	Insurance	Management Fee Income 6,616,778	19	5,664		445,320	381	13
14	30	Depreciation	Management Fee Income 6,616,778	19	36,741		445,320	2,473	14
15	32	Interest	Management Fee Income 6,616,778	19	3,185,539		445,320	214,392	15
16	34	Rent - Facility	Management Fee Income 6,616,778	19	251,434		445,320	16,922	16
17	35	Rent - Equipment	Management Fee Income 6,616,778	19	37,982		445,320	2,556	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 7,441,612	\$ 2,433,377		\$ 500,833	25

Facility Name & ID Number Provena St Joseph Center

0041871

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	17	Admin Salaries	Operating Expense	1,391,394	9	\$ 867,070	\$ 867,070	96,480	\$ 60,123	1
2	22	Employee Benefits	Operating Expense	1,391,394	9	659,854		96,480	45,755	2
3	30	Depreciation	Operating Expense	1,391,394	9	927,633		96,480	64,323	3
4	34	Rent Facility	Operating Expense	1,391,394	9	192,975		96,480	13,381	4
5	19	Admin Consulting,Other	Operating Expense	1,391,394	9	1,505,183		96,480	104,370	5
6	17	Information Systems Salaries	Operating Expense	2,155,920	9	399,935	399,935	149,760	27,781	6
7	22	Information Systems Benefits	Operating Expense	2,155,920	9	203,956		149,760	14,168	7
8	17	Information Systems - Other	Operating Expense	2,155,920	9	279,796		149,760	19,436	8
9	17	Admin Salaries	Direct Cost	1,391,394	9	440,776	440,776	96,480	30,564	9
10	17	Information Systems Salaries	Direct Cost	2,155,920	9	409,925	409,925	149,760	28,475	10
11	6	Information Systems - Equip Main	Direct Cost	2,155,920	9	367,627		149,760	25,537	11
12	19	Admin Consulting,Other	Direct Cost	1,391,394	9	349,224		96,480	24,215	12
13	32	Admin - Interest Expense	Direct Cost	1,391,394	9	5,051,741		96,480	350,290	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		\$ 808,418	25

Facility Name & ID Number Provena St Joseph Center

0041871 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		\$	\$		\$ 338,221	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				\$	\$		\$ 338,221	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									\$ 214,392	1									
2											2									
3											3									
4											4									
5											5									
Working Capital																				
6											6									
7											7									
8											8									
9	TOTAL Facility Related					\$	\$			\$ 214,392	9									
B. Non-Facility Related*																				
10											10									
11											11									
12											12									
13											13									
14	TOTAL Non-Facility Related					\$	\$			\$	14									
15	TOTALS (line 9+line14)					\$	\$			\$ 214,392	15									

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

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

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

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2007 report.		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	2
3. Under or (over) accrual (line 2 minus line 1).			\$	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)			\$ 104,040	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$ 104,040	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:				
2003	_____	8		
2004	_____	9		
2005	_____	10		
2006	_____	11		
2007	_____	12		
			FOR BHF USE ONLY	
13	FROM R. E. TAX STATEMENT FOR 2007	\$		13
14	PLUS APPEAL COST FROM LINE 5	\$		14
15	LESS REFUND FROM LINE 6	\$		15
16	AMOUNT TO USE FOR RATE CALCULATION	\$		16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 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 Joseph Center COUNTY Stephenson

FACILITY IDPH LICENSE NUMBER 0041871

CONTACT PERSON REGARDING THIS REPORT Lynda Olinski

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 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>To be determined</u>	<u></u>	\$ <u>104,040.00</u>	\$ <u>104,040.00</u>
2. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
3. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
4. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
5. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
6. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
TOTALS		\$ <u>104,040.00</u>	\$ <u>104,040.00</u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 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.

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number Provena St Joseph Center

0041871

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		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	120		1996	1996	\$ 2,500,000	\$ 62,500	40	\$ 62,500		\$ 781,250	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various		1996		3,510		10			3,510	9
10	Various		1997		21,208	1,135	8	1,135		17,235	10
11	Various		1998		6,818	186	7	186		6,818	11
12	Various		1999		80,775	5,818	11	5,818		55,686	12
13	Various		2000		9,480		5			9,480	13
14	Various		2001		25,584	827	8	827		20,895	14
15	Various		2002		45,550	2,077	10	2,077		33,970	15
16	Various		2003		77,509	7,199	11	7,199		40,167	16
17	Various		2004		41,423	5,583	11	5,583		25,249	17
18											18
19	BOILER AT ONEILL HALL/RE		2005		30,950	1,548	20	1,548		5,416	19
20	REPLACE FIREBOARD FOR AD		2005		21,223	2,122	10	2,122		7,428	20
21	SEWER LINE		2005		18,420	921	20	921		3,224	21
22	REPAIR UNDERGROUND STEAM		2005		6,710	671	10	671		2,349	22
23	AUTOMATIC DOOR EQUIPMENT		2005		6,284	628	10	628		2,199	23
24	INSTALLATION OF LARGE FL		2005		5,850	585	10	585		2,048	24
25	ASPHALT - CLF PROGRAM		2005		2,364	295	8	295		1,034	25
26	51" TOSHIBA HDTV MONITOR		2005		1,499	300	5	300		1,049	26
27	REMOVAL OF WALL IN TV LO		2005		965	97	10	97		338	27
28	TOWER ROOF REPAIRS		2005		795	80	10	80		318	28
29	REPLACE FIREBOARD FOR AD		2005		697	70	10	70		244	29
30	CARPETING		2005		563	113	5	113		394	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 Joseph Center

0041871

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	FIRE SPRINKLER	2006	\$ 7,155	\$ 477	15	\$ 477	\$	\$ 1,160	37
38	HIGH EFFICIENCY FURNACE	2006	7,125	475	15	475		1,188	38
39	REPAIR LOADING DOCK AREA	2006	3,664	458	8	458		1,145	39
40	WIRE KITCHEN RANGE HOOD	2006	3,405	341	10	341		1,022	40
41	SIDEWALK REPLACEMENT	2006	2,596	173	15	173		371	41
42	FLOORING FOR KITCHENETTE	2006	2,595	519	5	519		1,298	42
43	TREE REMOVAL	2006	2,500	500	5	500		1,250	43
44	RECOVER 2 L SHAPED AWNIN	2006	2,380	238	10	238		595	44
45	TRINITY HOUSE CARPETING	2006	1,741	348	5	348		871	45
46	PATCH CEILINGS IN HALLWAY	2006	800	80	10	80		200	46
47	LANDSCAPING - REMOVAL OF	2006	800	80	10	80		200	47
48	LANDSCAPING	2006	554	55	10	55		150	48
49	SEWER LINE FROM HOUSE TO	2006	116	39	3	39		97	49
50									50
51	ACCUTECH WANDERING AND V	2007	27,827	2,783	10	2,783		4,174	51
52	CONSTRUCTION, NEW LOBBY WALLS, ELECTRIC	2007	24,214	1,614	15	1,614		2,421	52
53	REWIRING OF ELECTRICAL F	2007	15,690	785	20	785		1,177	53
54	REPLACE HVAC, HEATING CHAPEL	2007	20,000	1,333	15	1,333		2,285	54
55	DINING ROOM PAINTING	2007	9,075	1,815	5	1,815		2,723	55
56	SCHEMATIC DESIGN & CONSTRUCTION NEIGHBORHOOD	2007	13,650	1,365	10	1,365		1,682	56
57	LANDSCAPING	2007	8,166	817	10	817		1,450	57
58	PAINTING OF NURSING HOME	2007	6,264	1,253	5	1,253		1,879	58
59	SCHEMATIC DESIGN & CONSTRUCTION THERAPY	2007	33,243	2,216	15	2,216		2,395	59
60	BOILER REPAIRS	2007	3,509	501	7	501		1,003	60
61	ENTRANCE CANOPY	2007	665	67	10	67		100	61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,105,911	\$ 111,085		\$ 111,085	\$	\$ 1,051,132	70

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

Facility Name & ID Number Provena St Joseph Center

0041871

Report Period Beginning:

01/01/08

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		\$ 3,105,911	\$ 111,085		\$ 111,085	\$	\$ 1,051,132	1
2									2
3									3
4	WIRING FOR FIRE ALARMS / TIE INTO NE	2008	46,500	2,325	20	4,650	2,325	2,325	4
5	ENTRANCE CANOPY / DRIVE	2008	3,568	357	10	714	357	357	5
6	REMODEL OF CHURCH	2008	42,100	1,053	20	2,105	1,053	1,053	6
7	ELECTRICAL WORK FOR MINISTRY	2008	8,100	203	20	405	203	203	7
8	NEW BASEBOARD COVERS FOR 64 RESIDENT	2008	21,020	1,051	10	2,102	1,051	1,051	8
9	REMODEL OF DINING ROOM	2008	9,030	376	12	753	376	376	9
10	WINDOWS FOR CLF 1ST FLOOR	2008	3,424	171	10	342	171	171	10
11	MOBILE CABINET	2008	2,135	107	10	213	107	107	11
12	FLAG POLE	2008	3,785	95	20	189	95	95	12
13	PARKING LOT REPAIRS, CONCRETE WALKWA	2008	74,818	4,676	8	9,352	4,676	4,676	13
14	CANOPY PROJECT	2008	4,868	162	15	325	162	162	14
15	DEPRECIATION FOR FIN 47 ASSETS	2008		4,845		4,845			15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,325,258	\$ 126,505		\$ 137,080	\$ 10,575	\$ 1,061,707	34

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

Facility Name & ID Number Provena St Joseph Center # 0041871 Report Period Beginning: 01/01/08 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	\$ 847,104	\$ 97,184	\$ 97,184	\$	10	\$ 281,533	71
72	Current Year Purchases	145,807	8,607	17,214	8,607	11	8,607	72
73	Fully Depreciated Assets	471,215				5	471,233	73
74			66,796	66,796				74
75	TOTALS	\$ 1,464,125	\$ 172,587	\$ 181,195	\$ 8,607		\$ 761,373	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Plant Engineering	1997 Dodge 2500	1997	\$ 24,090	\$	\$	\$	5	\$ 24,090	76
77	Plant Engineering	2001 Mercury Sable	2001	23,123				3	23,123	77
78	Plant Engineering	2003 Ford Van	2004	34,275	4,284	4,284		4	34,275	78
79	Plant Engineering	2006 Chevy Uplander	2007	15,649	3,912	3,912		4	5,868	79
80	TOTALS			\$ 97,137	\$ 8,197	\$ 8,197	\$		\$ 87,356	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)		\$ 6,286,520	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 307,288	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 326,471	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$ 19,182	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 1,910,437	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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

If NO, see instructions.

YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ _____			3
4	Additions				_____			4
5	Home Office Allocation				16,922			5
6					_____			6
7	TOTAL				\$ 16,922			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: \$ 11,408 Description: Nursing \$1,296; Plant Eng \$589; Administration \$6,967; Home Office \$2,556

(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.

Facility Name & ID Number Provena St Joseph Center# 0041871 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	\$	4,071	\$ 252,165	\$	4,071	\$ 252,165	1
2	Licensed Speech and Language Development Therapist	10a,3	hrs		111	6,944		111	6,944	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a,3	hrs		4,150	255,720		4,150	255,720	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				338,221		338,221	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			\$	8,332	\$ 514,829	\$ 338,221	8,332	\$ 853,050	14

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

Facility Name & ID Number Provena St Joseph Center# 0041871Report Period Beginning: 01/01/08

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	1,093,888	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 73,989,545	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(799,853)	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)	\$ (360,440)	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 Joseph Center# 0041871Report 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	\$ 5,139,799	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,139,799	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	790,535	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 790,535	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	45,519	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	294,215	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 339,734	23
D. Non-Operating Revenue			
24	Contributions	144,108	24
25	Interest and Other Investment Income***	931	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 145,039	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Purchase Rebates	216,827	28
28a	Misc Income & Gain/Loss SOFA	(13,188)	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 203,639	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,618,746	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,600,898	31
32	Health Care	2,942,445	32
33	General Administration	2,117,459	33
B. Capital Expense			
34	Ownership	353,696	34
C. Ancillary Expense			
35	Special Cost Centers	338,221	35
36	Provider Participation Fee	65,880	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,418,599	40
41	Income before Income Taxes (line 30 minus line 40)**	(799,853)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (799,853)	43

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

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

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

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

Facility Name & ID Number Provena St Joseph Center

0041871

Report Period Beginning: 01/01/08

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	1,612	2,080	\$ 74,442	\$ 35.79	1
2	Assistant Director of Nursing	1,788	2,076	64,494	31.07	2
3	Registered Nurses	9,169	9,910	326,087	32.90	3
4	Licensed Practical Nurses	30,160	32,664	601,991	18.43	4
5	CNAs & Orderlies	73,848	79,881	954,776	11.95	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,579	6,213	74,731	12.03	8
9	Activity Director	1,848	2,080	30,402	14.62	9
10	Activity Assistants	5,698	6,214	60,493	9.73	10
11	Social Service Workers	1,900	2,080	22,809	10.97	11
12	Dietician	1,844	2,080	41,086	19.75	12
13	Food Service Supervisor	552	624	7,607	12.19	13
14	Head Cook	5,874	6,341	70,048	11.05	14
15	Cook Helpers/Assistants	33,184	34,988	310,566	8.88	15
16	Dishwashers					16
17	Maintenance Workers	6,960	7,619	101,134	13.27	17
18	Housekeepers	16,933	18,041	157,283	8.72	18
19	Laundry					19
20	Administrator	1,868	2,080	88,023	42.32	20
21	Assistant Administrator	1,928	2,080	46,039	22.13	21
22	Other Administrative	6,098	6,781	70,366	10.38	22
23	Office Manager					23
24	Clerical	4,443	4,685	45,705	9.76	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>	1,784	1,856	46,899	25.27	33
34	TOTAL (lines 1 - 33)	213,070	230,373	\$ 3,194,981 *	\$ 13.87	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	208	\$ 13,306	1,3	35
36	Medical Director	\$1000/mo	12,000	9,3	36
37	Medical Records Consultant	31	2,315	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	7	435	11,3	44
45	Social Service Consultant	17	1,035	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	263	\$ 29,091		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	67	\$ 3,014	10,3	50
51	Licensed Practical Nurses	610	22,313	10,3	51
52	Certified Nurse Assistants/Aides	1,167	24,317	10,3	52
53	TOTAL (lines 50 - 52)	1,844	\$ 49,644		53

Facility Name & ID Number Provena St Joseph Center

0041871

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	
Theresa Parsek	Administrator	0	\$ 88,023	Workers' Compensation Insurance	\$ 88,200	IDPH License Fee	\$	
Administrative Staff	Asst. Administrator	0	46,039	Unemployment Compensation Insurance	9,126	Advertising: Employee Recruitment		
Administrative Staff	Bookkeeper	0	28,319	FICA Taxes	233,793	Health Care Worker Background Check		
Administrative Staff	Admissions	0		Employee Health Insurance	402,223	(Indicate # of checks performed <u>76</u>)		
Administrative Staff	Receptionist	0	45,705	Employee Meals		Patient Background Checks	<u>136</u>	
Administrative Staff	Admini Asst	0		Illinois Municipal Retirement Fund (IMRF)*		Employee Recruitment	5,257	
Administrative Staff	Human Resources	0	42,047	Life Insurance	15,257	Dues & Subscriptions	12,437	
TOTAL (agree to Schedule V, line 17, col. 1)				Pension	113,451	Advertising & Public Relations	32,894	
(List each licensed administrator separately.)			\$ 250,133	Employee Recognition	1,866			
B. Administrative - Other				Executive Benefits	7,165	Home Office Allocation	6,283	
Description			Amount	Employee Screenings	3,709	Less: Public Relations Expense	()	
Corp Service Fee			\$ 96,480	Home Office Allocation	176,568	Non-allowable advertising	(31,492)	
Corp Service IS Fee			149,760			Yellow page advertising	()	
Mgmt Fee			299,760	TOTAL (agree to Schedule V, line 22, col.8)			\$ 1,051,358	
Mgmt Fee Interest			145,560	E. Schedule of Non-Cash Compensation Paid to Owners or Employees				
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 691,560	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		\$ 22,791	Out-of-State Travel			\$	
Survey & Analytical Tools	Various		1,416					
Medical Waste	Various		372	In-State Travel			8,780	
Living Design	Various		507					
Outsourced Services	Various		1,083	Seminar Expense				
Collection Expense	Various		86					
Plant Maintenance	Various		966	Home Office Allocation			5,488	
Care Counselor	Various		1,008					
Surety Bond	Various		250	Entertainment Expense			()	
Anthing Aquatic	Various		526	(agree to Sch. V, line 24, col. 8)				
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			\$ 14,268	
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 29,005					

* 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 \$5349
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? Yes If YES, what is the capacity? 120
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 7 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 23,749 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 65,880
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. \$ 45,515
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? N/A
- d. Have vehicle usage logs been maintained? N/A
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: KPMG The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Not issued yet
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.