

Facility Name & ID Number Provena Cor Mariae Center

0041046 Report Period Beginning: 01/01/09 Ending: 12/31/09

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	73	Skilled (SNF)	73	26,645	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	89	Sheltered Care (SC)	89	32,485	5
6		ICF/DD 16 or Less			6
7	162	TOTALS	162	59,130	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF	4,319	8,988	11,914	25,221	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC		25,274		25,274	12
13	DD 16 OR LESS					13
14	TOTALS	4,319	34,262	11,914	50,495	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.40%

D. How many bed-hold days during this year were paid by the Department? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

N/A - None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES NO

I. On what date did you start providing long term care at this location?
Date started 6/5/1995

J. Was the facility purchased or leased after January 1, 1978?
YES Date 6/5/1995 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 73 and days of care provided 10,344

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/09 Fiscal Year: 12/31/09

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

Facility Name & ID Number Provena Cor Mariae Center # 0041046 Report Period Beginning: 01/01/09 Ending: 12/31/09

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	478,308	83,077	37,132	598,517		598,517		598,517		1
2	Food Purchase		399,710		399,710		399,710	2,766	402,476		2
3	Housekeeping	158,235	39,994		198,229		198,229		198,229		3
4	Laundry	33,060	2,098	103,951	139,109		139,109		139,109		4
5	Heat and Other Utilities			300,354	300,354		300,354	3,666	304,020		5
6	Maintenance	136,520	64,792	80,270	281,582		281,582	55,544	337,126		6
7	Other (specify):* Pastoral Care	43,618	3,826	22,782	70,226		70,226	(10,814)	59,412		7
8	TOTAL General Services	849,741	593,497	544,489	1,987,727		1,987,727	51,162	2,038,889		8
	B. Health Care and Programs										
9	Medical Director			19,250	19,250		19,250		19,250		9
10	Nursing and Medical Records	2,591,202	247,543	136,626	2,975,371		2,975,371		2,975,371		10
10a	Therapy			1,094,132	1,094,132		1,094,132		1,094,132		10a
11	Activities	262,745	17,485	11,302	291,532		291,532	295	291,827		11
12	Social Services	84,876	705	130	85,711		85,711		85,711		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,938,823	265,733	1,261,440	4,465,996		4,465,996	295	4,466,291		16
	C. General Administration										
17	Administrative	420,867	52,769	971,644	1,445,280		1,445,280	(412,676)	1,032,604		17
18	Directors Fees										18
19	Professional Services			19,324	19,324		19,324	65,007	84,331		19
20	Dues, Fees, Subscriptions & Promotions			60,639	60,639		60,639	(24,795)	35,844		20
21	Clerical & General Office Expenses			66,831	66,831		66,831	8,597	75,428		21
22	Employee Benefits & Payroll Taxes			957,737	957,737		957,737	308,102	1,265,839		22
23	Inservice Training & Education			4,444	4,444		4,444	3,208	7,652		23
24	Travel and Seminar			10,592	10,592		10,592	5,654	16,246		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			117,948	117,948		117,948	(80)	117,868		26
27	Other (specify):* Bad Debt			(12,683)	(12,683)		(12,683)	12,683			27
28	TOTAL General Administration	420,867	52,769	2,196,476	2,670,112		2,670,112	(34,300)	2,635,812		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,209,431	911,999	4,002,405	9,123,835		9,123,835	17,157	9,140,992		29

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

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

Facility Name & ID Number

Provena Cor Mariae Center

#0041046

Report Period Beginning:

01/01/09

Ending:

12/31/09

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			397,280	397,280		397,280	93,303	490,583			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							434,149	434,149			32
33	Real Estate Taxes			1,225	1,225		1,225		1,225			33
34	Rent-Facility & Grounds							28,605	28,605			34
35	Rent-Equipment & Vehicles			20,166	20,166		20,166	3,565	23,731			35
36	Other (specify):*											36
37	TOTAL Ownership			418,671	418,671		418,671	559,622	978,293			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			753,893	753,893		753,893	(370,369)	383,524			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			39,968	39,968		39,968		39,968			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			793,861	793,861		793,861	(370,369)	423,492			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,209,431	911,999	5,214,937	10,336,367		10,336,367	206,410	10,542,777			45

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

Provena Cor Mariae Center

ID# 0041046

Report Period Beginning: 01/01/09

Ending: 12/31/09

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Development Misc	\$ (10,814)	7	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(10,814)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Provena Cor Mariae Center# 0041046

Report Period Beginning:

01/01/09

Ending:

12/31/09

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	2,766	0	0	0	0	0	0	0	0	0	2,766	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	3,666	0	0	0	0	0	0	0	0	0	3,666	5
6	Maintenance	0	988	54,556	0	0	0	0	0	0	0	0	55,544	6
7	Other (specify):*	(10,814)	0	0	0	0	0	0	0	0	0	0	(10,814)	7
8	TOTAL General Services	(10,814)	7,420	54,556	0	51,162	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	295	0	0	0	0	0	0	0	0	0	295	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	295	0	0	0	0	0	0	0	0	0	295	16
	C. General Administration													
17	Administrative	0	(392,271)	(20,405)	0	0	0	0	0	0	0	0	(412,676)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	41,732	23,275	0	0	0	0	0	0	0	0	65,007	19
20	Fees, Subscriptions & Promotions	(32,166)	7,371	0	0	0	0	0	0	0	0	0	(24,795)	20
21	Clerical & General Office Expenses	0	8,597	0	0	0	0	0	0	0	0	0	8,597	21
22	Employee Benefits & Payroll Taxes	0	114,354	193,748	0	0	0	0	0	0	0	0	308,102	22
23	Inservice Training & Education	0	3,208	0	0	0	0	0	0	0	0	0	3,208	23
24	Travel and Seminar	0	5,654	0	0	0	0	0	0	0	0	0	5,654	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	(80)	0	0	0	0	0	0	0	0	0	(80)	26
27	Other (specify):*	12,683	0	0	0	0	0	0	0	0	0	0	12,683	27
28	TOTAL General Administration	(19,483)	(211,435)	196,618	0	(34,300)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(30,297)	(203,720)	251,174	0	17,157	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Provena Cor Mariae Center# 0041046

Report Period Beginning:

01/01/09

Ending:

12/31/09

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

	Capital Expense	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)	
	D. Ownership													
30	Depreciation	11,419	0	81,884	0	0	0	0	0	0	0	0	93,303	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(10,820)	0	444,969	0	0	0	0	0	0	0	0	434,149	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	28,605	0	0	0	0	0	0	0	0	28,605	34
35	Rent-Equipment & Vehicles	0	0	3,565	0	0	0	0	0	0	0	0	3,565	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	599	0	559,023	0	559,622	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	(370,369)	0	0	0	0	0	0	0	0	0	0	(370,369)	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	(370,369)	0	0	0	0	0	0	0	0	0	0	(370,369)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(400,067)	(203,720)	810,197	0	0	0	0	0	0	0	0	206,410	45

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	1.00%	\$ 2,766	\$ 2,766	1
2	V	5 Utilities		Provena Senior Services	1.00%	3,666	3,666	2
3	V	6 Maintenance - Other		Provena Senior Services	1.00%	988	988	3
4	V	11 Activities-Special Events		Provena Senior Services	1.00%	295	295	4
5	V	17 Admin - Misc. Other		Provena Senior Services	1.00%	7,575	7,575	5
6	V	17 Administrative Salaries	662,850	Provena Senior Services	1.00%	263,004	(399,846)	6
7	V	19 Professional Services		Provena Senior Services	1.00%	41,732	41,732	7
8	V	20 Dues,Subscriptions		Provena Senior Services	1.00%	7,371	7,371	8
9	V	21 Clerical Supplies		Provena Senior Services	1.00%	8,597	8,597	9
10	V	22 Employee Benefits		Provena Senior Services	1.00%	114,354	114,354	10
11	V	23 Education/Conference		Provena Senior Services	1.00%	3,208	3,208	11
12	V	24 Travel		Provena Senior Services	1.00%	5,654	5,654	12
13	V	26 Insurance		Provena Senior Services	1.00%	(80)	(80)	13
14	Total		\$ 662,850			\$ 459,130	\$ * (203,720)	14

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

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	1.00%	\$ 3,687	\$ 3,687 15
16	V	32 Interest		Provena Senior Services	1.00%	223,809	223,809 16
17	V	34 Rent - Facility		Provena Senior Services	1.00%	28,605	28,605 17
18	V	35 Rent - Equipment		Provena Senior Services	1.00%	3,565	3,565 18
19	V	17 Admin Salaries	123,360	Provena Health Services	1.00%	103,370	(19,990) 19
20	V	22 Employee Benefits		Provena Health Services	1.00%	66,061	66,061 20
21	V	30 Depreciation		Provena Health Services	1.00%	78,197	78,197 21
22	V	19 Admin Consulting, Other		Provena Health Services	1.00%	23,275	23,275 22
23	V	17 Information Systems Salaries	185,434	Provena Health Services	1.00%	98,437	(86,997) 23
24	V	22 Information Systems Benefits		Provena Health Services	1.00%	36,724	36,724 24
25	V	17 Information Systems - Other		Provena Health Services	1.00%	31,552	31,552 25
26	V	17 Admin Salaries		Provena Health Services	1.00%	14,275	14,275 26
27	V	22 Employee Benefits		Provena Health Services	1.00%	58,850	58,850 27
28	V	17 Information Systems Salaries		Provena Health Services	1.00%	40,755	40,755 28
29	V	22 Information Systems Benefits		Provena Health Services	1.00%	32,113	32,113 29
30	V	6 Information Systems - Equip Maint		Provena Health Services	1.00%	54,556	54,556 30
31	V	32 Admin - Interest Expense		Provena Health Services	1.00%	221,160	221,160 31
32	V	39 Ancillary Services - Other	753,893	Provena Senior Services Pharmacy	1.00%	753,893	
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 1,062,687			\$ 1,872,884	\$ * 810,197 39

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

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VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number Provena Cor Mariae Center

0041046

Report Period Beginning:

01/01/09

Ending: 12/31/09

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, IL 60448
 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	6,810,879	19	\$ 28,423	\$ 662,850	\$ 2,766	1	
2	5	Utilities	Management Fee Income	6,810,879	19	37,672	662,850	3,666	2	
3	6	Maintenance - Other	Management Fee Income	6,810,879	19	10,148	662,850	988	3	
4	11	Activities-Special Events	Management Fee Income	6,810,879	19	3,032	662,850	295	4	
5	17	Admin - Misc. Other	Management Fee Income	6,810,879	19	77,835	662,850	7,575	5	
6	17	Administrative Salaries	Management Fee Income	6,810,879	19	2,702,403	2,702,403	662,850	263,004	6
7	19	Professional Services	Management Fee Income	6,810,879	19	428,802	662,850	41,732	7	
8	20	Dues,Subscriptions	Management Fee Income	6,810,879	19	75,736	662,850	7,371	8	
9	21	Clerical Supplies	Management Fee Income	6,810,879	19	88,333	662,850	8,597	9	
10	22	Employee Benefits	Management Fee Income	6,810,879	19	1,175,007	662,850	114,354	10	
11	23	Education/Conference	Management Fee Income	6,810,879	19	32,966	662,850	3,208	11	
12	24	Travel	Management Fee Income	6,810,879	19	58,096	662,850	5,654	12	
13	26	Insurance	Management Fee Income	6,810,879	19	(818)	662,850	(80)	13	
14	30	Depreciation	Management Fee Income	6,810,879	19	37,881	662,850	3,687	14	
15	32	Interest	Management Fee Income	6,810,879	19	2,299,667	662,850	223,809	15	
16	34	Rent - Facility	Management Fee Income	6,810,879	19	293,923	662,850	28,605	16	
17	35	Rent - Equipment	Management Fee Income	6,810,879	19	36,626	662,850	3,565	17	
18									18	
19									19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 7,385,732	\$ 2,702,403	\$ 718,796	25	

Facility Name & ID Number Provena Cor Mariae Center

0041046

Report Period Beginning:

01/01/09

Ending: 12/31/09

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	1,290,832	9	\$ 1,081,653	\$ 1,081,653	123,360	\$ 103,370	1
2	22	Employee Benefits	Operating Expense	1,290,832	9	691,262		123,360	66,061	2
3	30	Depreciation	Operating Expense	1,290,832	9	818,246		123,360	78,197	3
4	34	Rent Facility	Operating Expense	1,290,832	9	243,546		123,360	23,275	4
5	19	Admin Consulting,Other	Operating Expense	1,290,832	9	1,030,040		123,360	98,437	5
6	17	Information Systems Salaries	Operating Expense	1,941,141	9	384,433	384,433	185,434	36,724	6
7	22	Information Systems Benefits	Operating Expense	1,941,141	9	330,293		185,434	31,552	7
8	17	Information Systems - Other	Operating Expense	1,941,141	9	149,433		185,434	14,275	8
9	17	Admin Salaries	Direct Cost	1,290,832	9	615,798	615,798	123,360	58,850	9
10	17	Information Systems Salaries	Direct Cost	1,941,141	9	426,627	426,627	185,434	40,755	10
11	6	Information Systems - Equip Maint	Direct Cost	1,941,141	9	336,162		185,434	32,113	11
12	19	Admin Consulting,Other	Direct Cost	1,290,832	9	570,873		123,360	54,556	12
13	32	Admin - Interest Expense	Direct Cost	1,290,832	9	2,314,209		123,360	221,160	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					\$ 8,992,575	\$ 2,508,511		\$ 859,325	25

Facility Name & ID Number Provena Cor Mariae Center

0041046

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

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		\$	\$		\$ 753,893	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				\$	\$		\$ 753,893	25

Facility Name & ID Number

Provena Cor Mariae Center

0041046

Report Period Beginning:

01/01/09

Ending:

12/31/09

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		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					\$	\$			\$ 223,809	1							
2											2							
3											3							
4											4							
5											5							
Working Capital																		
6											6							
7											7							
8											8							
9	TOTAL Facility Related					\$	\$			\$ 223,809	9							
B. Non-Facility Related*																		
10											10							
11											11							
12											12							
13											13							
14	TOTAL Non-Facility Related					\$	\$			\$	14							
15	TOTALS (line 9+line14)					\$	\$			\$ 223,809	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.)

Facility Name & ID Number Provena Cor Mariae Center

0041046

Report Period Beginning:

01/01/09

Ending:

12/31/09

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

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

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

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

XI. OWNERSHIP COSTS:

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

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	89	1995	1964	\$ 1,035,000	\$ 33,333	30	\$ 33,333	\$	\$ 518,333
5	63		1997	2,508,246	62,711	40	62,711		768,015
6	10		2005	955,154	38,384	25	38,384		172,277
7									
8									
Improvement Type**									
9	Various		1995	131,756	6,588	18	6,588		93,034
10	Various		1996	144,747	6,134	15	6,134		119,907
11	Various		1997	513,596	24,412	14	24,412		358,230
12	Various		1998	174,397	5,239	13	5,239		77,473
13	Various		1999	10,976	22	6	22		10,976
14	Various		2000	39,900	1,176	6	1,176		39,312
15	Various		2001	48,414	3,380	9	3,380		34,996
16	Various		2002	118,018	9,196	10	9,196		74,157
17	Various		2003	165,948	6,933	10	6,933		137,138
18	Various		2004	90,350	8,584	9	8,584		52,773
19	Various		2005	36,791	4,865		4,865		14,534
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
36									

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Provena Cor Mariae Center

0041046

Report Period Beginning:

01/01/09

Ending:

12/31/09

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	PATIO ROOF /FRONT ENTRAN	2006	\$ 42,366	\$ 4,237	12	\$ 4,237	\$ 0	\$ 14,828	37
38	FENCING INSTALLATION	2006	35,687	2,974	10	2,974	0	10,409	38
39	COOLING TOWER REPLACEMEN	2006	33,800	2,253	15	2,253	(0)	7,887	39
40	SHELTERED CARE SHOWER	2006	23,500	1,567	15	1,567		4,700	40
41									41
42									42
43	BATHROOM REMODEL	2007	20,454	1,364	15	1,364	0	3,221	43
44	CARPET REPLACEMENT FOR A	2007	14,500	2,900	7	2,900		7,250	44
45	REPAIRS TO FIRE PUMP SYS	2007	4,571	653	5	653	(0)	1,633	45
46									46
47	TRANSFER SWITCHES	2008	34,753	4,965	7	4,965	0	7,447	47
48	WATER MAIN BREAK REPAIR	2008	3,607	361	10	361	0	541	48
49	ELEVATOR	2008	141,962	7,098	20	7,098	(0)	10,647	49
50	WATER MAIN BREAK (REPAIR)	2008	7,074	707	10	707	(0)	1,061	50
51	CAPITAL LEASE - COPIER	2008	23,956	4,791	5	4,791		7,187	51
52	DEPRECIATION FOR FIN 47 ASSETS	2008		5,744		5,744		27,786	52
53									53
54	BOILER INSTALLATION	2009	16,759	419	20	838	419	419	54
55	PATIO PROJECT	2009	15,387	513	15	1,026	513	513	55
56	BOILER REPAIRS	2009	3,810	408	7	816	408	408	56
57	CARPETING	2009	5,965	597	5	1,193	597	597	57
58	KITCHEN HOOD WIRING	2009	2,795	140	10	280	140	140	58
59	PARKIN LOT REPAIRS	2009	18,336	1,146	8	2,292	1,146	1,146	59
60	PATIO PROJECT	2009	100,228	2,506	20	5,011	2,506	2,506	60
61	CARPETING FOR 9 MED APTS	2009	12,466	1,247	5	2,493	1,247	1,247	61
62	PARTIAL RE-ROOF	2009	17,740	887	10	1,774	887	887	62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 6,553,010	\$ 258,432		\$ 266,294	\$ 7,862	\$ 2,583,613	70

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

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	\$ 1,672,861	\$ 131,983	\$ 131,983	\$ 0	11	\$ 852,693	71
72	Current Year Purchases	51,926	3,556	7,112	3,556	10	3,556	72
73	Fully Depreciated Assets	358,807				6	358,807	73
74	Home Office Allocation		81,884	81,884				74
75	TOTALS	\$ 2,083,594	\$ 217,423	\$ 220,979	\$ 3,556		\$ 1,215,057	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Plant Engineering	2000 FORD ELDORADO	2000	\$ 42,500	\$ 4,250	\$ 4,250		10	\$ 40,375	76
77	Plant Engineering	1991 Chevy Pickup	1995	14,000				5	14,000	77
78		Non Care Portion		(15,062)		(941)	(941)			78
79										79
80	TOTALS			\$ 41,438	\$ 4,250	\$ 3,309	\$ (941)		\$ 54,375	80

E. Summary of Care-Related Assets

	1	2		
	Reference	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)	\$ 9,348,937	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 480,105	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 490,583	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 10,478	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,853,045	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				28,605			5
6								6
7	TOTAL				\$ 28,605			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: \$ _____ Description: Nursing \$77,324; Sup Liv \$146; Administration \$20,117; Home Office \$ 3,565

(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. _____/2010 \$ _____

13. _____/2011 \$ _____

14. _____/2012 \$ _____

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8		
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)			
			Units of Service			Units	Cost						
1	Licensed Occupational Therapist	10a,3	hrs	\$	7,590	\$	484,534	\$	7,590	\$	484,534	1	
2	Licensed Speech and Language Development Therapist	10a,3	hrs		1,423		91,609		1,423		91,609	2	
3	Licensed Recreational Therapist		hrs									3	
4	Licensed Physical Therapist	10a,3	hrs		8,095		517,990		8,095		517,990	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 prescripts					755,674			755,674	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10	
11	Academic Education		hrs									11	
12	Other (specify):											12	
13	Other (specify):											13	
14	TOTAL			\$	17,108	\$	1,094,133	\$	755,674	17,108	\$	1,849,807	14

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

Facility Name & ID Number Provena Cor Mariae Center# 0041046Report Period Beginning: 01/01/09Ending: 12/31/09

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/09

(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	\$ 12,337,938	\$	1
2	Cash-Patient Deposits	107,856		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	12,517,618		3
4	Supply Inventory (priced at)	682,337		4
5	Short-Term Investments			5
6	Prepaid Insurance	21,512		6
7	Other Prepaid Expenses	152,000		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 25,819,261	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments	7,398,236		12
13	Land	6,820,469		13
14	Buildings, at Historical Cost	85,287,605		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	18,957,385		16
17	Accumulated Depreciation (book methods)	(56,011,567)		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>	106,392		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 62,558,520	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 88,377,781	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 5,373,551	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,366,224		28
29	Short-Term Notes Payable	52,481		29
30	Accrued Salaries Payable	3,681,842		30
31	Accrued Taxes Payable (excluding real estate taxes)	113,556		31
32	Accrued Real Estate Taxes(Sch.IX-B)	1,098,515		32
33	Accrued Interest Payable	17,377		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Due to Related Party</u>	913,853		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 12,617,399	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	1,170,110		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	382,071		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)	\$ 1,990,925	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 14,608,324	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 73,769,457	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 88,377,781	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1	
		Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 73,629,105	1
2	Restatements (describe):		2
3	Transfer to Affiliates	(5,368,199)	3
4	Adj. To reconcile consolidated equity & consolidated income	4,345,430	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 72,606,336	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	465,694	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	857,343	11
12	Expenditures for Specific Purposes	(159,916)	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)	\$ 1,163,121	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)	\$ 73,769,457	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Provena Cor Mariae Center# 0041046Report Period Beginning: 01/01/09Ending: 12/31/09

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 7,829,527	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,829,527	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,721,334	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,721,334	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	732,222	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	7,981	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 740,203	23
D. Non-Operating Revenue			
24	Contributions	17,376	24
25	Interest and Other Investment Income***	10,820	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 28,196	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Purchase Rebates</u>	370,369	28
28a	<u>Misc Income & Gain/Loss SOFA</u>	112,432	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 482,801	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,802,061	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,987,727	31
32	Health Care	4,465,996	32
33	General Administration	2,670,112	33
B. Capital Expense			
34	Ownership	418,671	34
C. Ancillary Expense			
35	Special Cost Centers	753,893	35
36	Provider Participation Fee	39,968	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,336,367	40
41	Income before Income Taxes (line 30 minus line 40)**	465,694	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 465,694	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.

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

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

Facility Name & ID Number **Provena Cor Mariae Center**

0041046

Report Period Beginning:

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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	1,992	2,080	\$ 92,674	\$ 44.55	1
2	Assistant Director of Nursing	1,442	1,518	47,624	31.37	2
3	Registered Nurses	19,966	22,552	627,567	27.83	3
4	Licensed Practical Nurses	24,244	27,092	695,088	25.66	4
5	CNAs & Orderlies	72,121	79,159	1,023,989	12.94	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,911	5,235	93,755	17.91	8
9	Activity Director	3,134	3,526	62,832	17.82	9
10	Activity Assistants	17,460	18,843	201,864	10.71	10
11	Social Service Workers	5,077	5,468	85,218	15.58	11
12	Dietician	1,964	2,264	62,263	27.50	12
13	Food Service Supervisor	3,191	3,444	42,543	12.35	13
14	Head Cook	3,453	3,920	46,208	11.79	14
15	Cook Helpers/Assistants	34,676	36,926	327,366	8.87	15
16	Dishwashers					16
17	Maintenance Workers	7,099	8,052	143,262	17.79	17
18	Housekeepers	16,224	17,523	158,234	9.03	18
19	Laundry	3,611	3,814	34,450	9.03	19
20	Administrator	1,912	2,080	124,935	60.06	20
21	Assistant Administrator	1,560	1,680	65,112	38.76	21
22	Other Administrative	5,730	6,301	143,442	22.76	22
23	Office Manager	3,426	1,645	26,096	15.86	23
24	Clerical	4,600	7,103	61,282	8.63	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>	1,824	1,978	43,627	22.06	33
34	TOTAL (lines 1 - 33)	239,617	262,203	\$ 4,209,431 *	\$ 16.05	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	367	\$ 24,814	1,3	35
36	Medical Director	\$1750/mo	19,250	9,3	36
37	Medical Records Consultant	31	2,176	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	48	3,377	11,3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	446	\$ 49,617		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	17	\$ 625	10,3	50
51	Licensed Practical Nurses	512	17,654	10,3	51
52	Certified Nurse Assistants/Aides	518	10,012	10,3	52
53	TOTAL (lines 50 - 52)	1,047	\$ 28,291		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Teresa Wester-Peters	Administrator	0	\$ 124,935	Workers' Compensation Insurance	\$ 120,300	IDPH License Fee	\$	
Administrative Staff	Admissions	0	73,442	Unemployment Compensation Insurance	27,945	Advertising: Employee Recruitment		
Administrative Staff	Human Resource	0	40,284	FICA Taxes	302,226	Health Care Worker Background Check		
Administrative Staff	Admin Asst	0	36,125	Employee Health Insurance	345,658	(Indicate # of checks performed <u>84</u>)		
Administrative Staff	Receptionist	0	47,873	Employee Meals		Patient Background Checks	<u>390</u>	
Administrative Staff	Office Manager	0	33,096	Illinois Municipal Retirement Fund (IMRF)*		Employee Recruitment	3,407	
Administrative Staff	Asst Administrator	0	65,112	Life Insurance	14,950	Dues & Subscription	17,414	
TOTAL (agree to Schedule V, line 17, col. 1)				Pension	118,975	Advertising & Public Relations	39,818	
(List each licensed administrator separately.)			\$ 420,867	Employee Recognition	0			
B. Administrative - Other				Executive Benefits	7,672	Home Office Allocation	7,371	
Description			Amount	Employment Screenings	20,011	Less: Public Relations Expense	()	
Corproate Service Fee			\$ 123,360	Home Office Allocation	308,102	Non-allowable advertising	(32,166)	
Corporate Fee			185,434			Yellow page advertising	()	
Mgmt Fee			432,846	TOTAL (agree to Schedule V, line 22, col.8)			\$ 1,265,839	
Mngt Fee Interest			230,004	E. Schedule of Non-Cash Compensation Paid to Owners or Employees				
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 971,644	Description	Line #	Amount	G. Schedule of Travel and Seminar**	
(Attach a copy of any management service agreement)				N/A		\$	Description	Amount
C. Professional Services							Out-of-State Travel	\$ 1,500
Vendor/Payee	Type		Amount					
Legal Expense	Various		\$ 0				In-State Travel	9,092
Collection Expense	Various		1,800				Seminar Expense	
Shredding/Storage	Various		1,583				Home Office Allocation	5,654
Survey & Analytical Tools	Various		3,214				Entertainment Expense	()
Outsourced Services	Various		4,414				TOTAL (agree to Sch. V, line 24, col. 8)	
Care Counselor	Various		8,313				\$ 16,246	
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			\$	
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 19,324					

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Provena Cor Mariae Center

0041046

Report Period Beginning:

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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 \$7,057
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? Yes If YES, what is the capacity? 162
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 7 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 30,421 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 39,968
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? No Indicate the amount. \$ None
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? Yes
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: KPMG
- (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.