

Facility Name & ID Number Provena St Anne Center

0041731 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	120	Skilled (SNF)	120	43,800	1
2		Skilled Pediatric (SNF/PED)			2
3	59	Intermediate (ICF)	59	21,535	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	179	TOTALS	179	65,335	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	12,864	11,379	19,077	43,320	8
9	SNF/PED					9
10	ICF	6,324	5,594		11,918	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	19,188	16,973	19,077	55,238	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.55%

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 10/6/1986

J. Was the facility purchased or leased after January 1, 1978?
YES Date 10/6/1986 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 15,823

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

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

Facility Name & ID Number Provena St Anne Center # 0041731 Report Period Beginning: 01/01/09 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	533,221	82,439	38,578	654,238		654,238		654,238		1
2	Food Purchase		447,809		447,809		447,809	(120,475)	327,334		2
3	Housekeeping	151,066	30,218		181,284		181,284		181,284		3
4	Laundry	9,351	15,311	146,957	171,619		171,619		171,619		4
5	Heat and Other Utilities			201,055	201,055		201,055	4,705	205,760		5
6	Maintenance	145,612	43,024	57,394	246,030		246,030	79,019	325,049		6
7	Other (specify):* Pastoral Care	47,450	1,978	30,051	79,479		79,479	1,254	80,733		7
8	TOTAL General Services	886,700	620,779	474,035	1,981,514		1,981,514	(35,497)	1,946,017		8
	B. Health Care and Programs										
9	Medical Director			21,000	21,000		21,000		21,000		9
10	Nursing and Medical Records	4,632,044	363,142	206,626	5,201,812		5,201,812		5,201,812		10
10a	Therapy			1,573,196	1,573,196		1,573,196		1,573,196		10a
11	Activities	137,866	6,984	8,874	153,724		153,724	379	154,103		11
12	Social Services	105,758			105,758		105,758		105,758		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	4,875,668	370,126	1,809,696	7,055,490		7,055,490	379	7,055,869		16
	C. General Administration										
17	Administrative	526,380	36,068	1,290,902	1,853,350		1,853,350	(532,586)	1,320,764		17
18	Directors Fees										18
19	Professional Services			35,434	35,434		35,434	86,730	122,164		19
20	Dues, Fees, Subscriptions & Promotions			48,439	48,439		48,439	(12,980)	35,459		20
21	Clerical & General Office Expenses			66,458	66,458		66,458	11,033	77,491		21
22	Employee Benefits & Payroll Taxes			1,558,595	1,558,595		1,558,595	422,925	1,981,520		22
23	Inservice Training & Education			10,719	10,719		10,719	4,118	14,837		23
24	Travel and Seminar			10,600	10,600		10,600	7,257	17,857		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			166,098	166,098		166,098	(102)	165,996		26
27	Other (specify):* Bad Debt			29,525	29,525		29,525	(29,525)			27
28	TOTAL General Administration	526,380	36,068	3,216,770	3,779,218		3,779,218	(43,130)	3,736,088		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,288,748	1,026,973	5,500,501	12,816,222		12,816,222	(78,248)	12,737,974		29

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

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

Facility Name & ID Number

Provena St Anne Center

#0041731

Report Period Beginning:

01/01/09

Ending:

12/31/09

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			393,848	393,848		393,848	128,435	522,283			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							582,629	582,629			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds							36,713	36,713			34
35	Rent-Equipment & Vehicles			27,900	27,900		27,900	4,575	32,475			35
36	Other (specify):*											36
37	TOTAL Ownership			421,748	421,748		421,748	752,352	1,174,100			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			1,216,977	1,216,977		1,216,977	(539,571)	677,406			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			98,003	98,003		98,003		98,003			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			1,314,980	1,314,980		1,314,980	(539,571)	775,409			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,288,748	1,026,973	7,237,229	14,552,950		14,552,950	134,533	14,687,483			45

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

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	(124,025)	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	12,260	30		9
10	Interest and Other Investment Income	(19,803)	32		10
11	Discounts, Allowances, Rebates & Refunds	(539,571)	39		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,200)			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	(29,525)	27		24
25	Fund Raising, Advertising and Promotional	(22,440)	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)	\$ (724,304)		\$	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)	856,383		34
35	Other- Attach Schedule	1,254		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 857,637		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 133,333		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						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY							
48		49		50		51	52

Provena St Anne Center

ID# 0041731

Report Period Beginning: 01/01/09

Ending: 12/31/09

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Health Insurance	\$ 19,350	7	1
2	Office Supplies	(399)	7	2
3	Other Supplies	(134)	7	3
4	Advert/ Marketing	(690)	7	4
5	Rental/ Lease-Equip	(239)	7	5
6	Miscellaneous	(7,092)	7	6
7	Gifts	(9,542)	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	1,254		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Provena St Anne Center# 0041731

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	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(124,025)	3,550	0	0	0	0	0	0	0	0	0	(120,475)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	4,705	0	0	0	0	0	0	0	0	0	4,705	5
6	Maintenance	0	1,268	77,751	0	0	0	0	0	0	0	0	79,019	6
7	Other (specify):*	1,254	0	0	0	0	0	0	0	0	0	0	1,254	7
8	TOTAL General Services	(122,771)	9,523	77,751	0	(35,497)	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	379	0	0	0	0	0	0	0	0	0	379	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	379	0	0	0	0	0	0	0	0	0	379	16
	C. General Administration													
17	Administrative	0	(503,453)	(29,133)	0	0	0	0	0	0	0	0	(532,586)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	53,560	33,170	0	0	0	0	0	0	0	0	86,730	19
20	Fees, Subscriptions & Promotions	(22,440)	9,460	0	0	0	0	0	0	0	0	0	(12,980)	20
21	Clerical & General Office Expenses	0	11,033	0	0	0	0	0	0	0	0	0	11,033	21
22	Employee Benefits & Payroll Taxes	0	146,766	276,159	0	0	0	0	0	0	0	0	422,925	22
23	Inservice Training & Education	0	4,118	0	0	0	0	0	0	0	0	0	4,118	23
24	Travel and Seminar	0	7,257	0	0	0	0	0	0	0	0	0	7,257	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	(102)	0	0	0	0	0	0	0	0	0	(102)	26
27	Other (specify):*	(29,525)	0	0	0	0	0	0	0	0	0	0	(29,525)	27
28	TOTAL General Administration	(51,965)	(271,361)	280,196	0	(43,130)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(174,736)	(261,459)	357,947	0	(78,248)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Provena St Anne Center# 0041731

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	12,260	0	116,175	0	0	0	0	0	0	0	0	128,435	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(19,803)	0	602,432	0	0	0	0	0	0	0	0	582,629	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	36,713	0	0	0	0	0	0	0	0	36,713	34
35	Rent-Equipment & Vehicles	0	0	4,575	0	0	0	0	0	0	0	0	4,575	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(7,543)	0	759,895	0	752,352	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	(539,571)	0	0	0	0	0	0	0	0	0	0	(539,571)	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	(539,571)	0	0	0	0	0	0	0	0	0	0	(539,571)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(721,850)	(261,459)	1,117,842	0	134,533	45							

Facility Name & ID Number

Provena St Anne Center

0041731

Report Period Beginning:

01/01/09

Ending:

12/31/09

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		See Attached		See Attached		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	2 Food	\$	Provena Senior Services	100.00%	\$ 3,550	\$ 3,550	1
2	V	5 Utilities		Provena Senior Services	100.00%	4,705	4,705	2
3	V	6 Maintenance - Other		Provena Senior Services	100.00%	1,268	1,268	3
4	V	11 Activities-Special Events		Provena Senior Services	100.00%	379	379	4
5	V	17 Admin - Misc. Other		Provena Senior Services	100.00%	9,722	9,722	5
6	V	17 Administrative Salaries	850,722	Provena Senior Services	100.00%	337,547	(513,175)	6
7	V	19 Professional Services		Provena Senior Services	100.00%	53,560	53,560	7
8	V	20 Dues,Subscriptions		Provena Senior Services	100.00%	9,460	9,460	8
9	V	21 Clerical Supplies		Provena Senior Services	100.00%	11,033	11,033	9
10	V	22 Employee Benefits		Provena Senior Services	100.00%	146,766	146,766	10
11	V	23 Education/Conference		Provena Senior Services	100.00%	4,118	4,118	11
12	V	24 Travel		Provena Senior Services	100.00%	7,257	7,257	12
13	V	26 Insurance		Provena Senior Services	100.00%	(102)	(102)	13
14	Total		\$ 850,722			\$ 589,263	\$ * (261,459)	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	100.00%	\$ 4,732	\$ 4,732
16	V	32 Interest		Provena Senior Services	100.00%	287,243	287,243
17	V	34 Rent - Facility		Provena Senior Services	100.00%	36,713	36,713
18	V	35 Rent - Equipment		Provena Senior Services	100.00%	4,575	4,575
19	V	17 Admin Salaries	175,808	Provena Health Services	100.00%	147,318	(28,490)
20	V	22 Employee Benefits		Provena Health Services	100.00%	94,148	94,148
21	V	30 Depreciation		Provena Health Services	100.00%	111,443	111,443
22	V	19 Admin Consulting, Other		Provena Health Services	100.00%	33,170	33,170
23	V	17 Information Systems Salaries	264,372	Provena Health Services	100.00%	140,289	(124,083)
24	V	22 Information Systems Benefits		Provena Health Services	100.00%	52,358	52,358
25	V	17 Information Systems - Other		Provena Health Services	100.00%	44,984	44,984
26	V	17 Admin Salaries		Provena Health Services	100.00%	20,352	20,352
27	V	22 Employee Benefits		Provena Health Services	100.00%	83,870	83,870
28	V	17 Information Systems Salaries		Provena Health Services	100.00%	58,104	58,104
29	V	22 Information Systems Benefits		Provena Health Services	100.00%	45,783	45,783
30	V	6 Information Systems - Equip Maint		Provena Health Services	100.00%	77,751	77,751
31	V	32 Admin - Interest Expense		Provena Health Services	100.00%	315,189	315,189
32	V	39 Ancillary Services - Other	1,216,977	Provena Senior Services Pharmacy	100.00%	1,216,977	
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 1,657,157			\$ 2,774,999	\$ * 1,117,842

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

Facility Name & ID Number Provena St Anne Center # 0041731 Report Period Beginning: 01/01/09 Ending: 12/31/09

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number Provena St Anne Center

0041731

Report Period Beginning:

01/01/09

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, 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	6,810,879	19	\$ 28,423	\$ 850,722	\$ 3,550	1
2	5	Utilities	Management Fee Income	6,810,879	19	37,672	850,722	4,705	2
3	6	Maintenance - Other	Management Fee Income	6,810,879	19	10,148	850,722	1,268	3
4	11	Activities-Special Events	Management Fee Income	6,810,879	19	3,032	850,722	379	4
5	17	Admin - Misc. Other	Management Fee Income	6,810,879	19	77,835	850,722	9,722	5
6	17	Administrative Salaries	Management Fee Income	6,810,879	19	2,702,403	2,702,403	337,547	6
7	19	Professional Services	Management Fee Income	6,810,879	19	428,802	850,722	53,560	7
8	20	Dues,Subscriptions	Management Fee Income	6,810,879	19	75,736	850,722	9,460	8
9	21	Clerical Supplies	Management Fee Income	6,810,879	19	88,333	850,722	11,033	9
10	22	Employee Benefits	Management Fee Income	6,810,879	19	1,175,007	850,722	146,766	10
11	23	Education/Conference	Management Fee Income	6,810,879	19	32,966	850,722	4,118	11
12	24	Travel	Management Fee Income	6,810,879	19	58,096	850,722	7,257	12
13	26	Insurance	Management Fee Income	6,810,879	19	(818)	850,722	(102)	13
14	30	Depreciation	Management Fee Income	6,810,879	19	37,881	850,722	4,732	14
15	32	Interest	Management Fee Income	6,810,879	19	2,299,667	850,722	287,243	15
16	34	Rent - Facility	Management Fee Income	6,810,879	19	293,923	850,722	36,713	16
17	35	Rent - Equipment	Management Fee Income	6,810,879	19	36,626	850,722	4,575	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 7,385,732	\$ 2,702,403	\$ 922,526	25

Facility Name & ID Number Provena St Anne Center

0041731

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	175,808	\$ 147,318	1
2	22	Employee Benefits	Operating Expense	1,290,832	9	691,262		175,808	94,148	2
3	30	Depreciation	Operating Expense	1,290,832	9	818,246		175,808	111,443	3
4	34	Rent Facility	Operating Expense	1,290,832	9	243,546		175,808	33,170	4
5	19	Admin Consulting,Other	Operating Expense	1,290,832	9	1,030,040		175,808	140,289	5
6	17	Information Systems Salaries	Operating Expense	1,941,141	9	384,433	384,433	264,372	52,358	6
7	22	Information Systems Benefits	Operating Expense	1,941,141	9	330,293		264,372	44,984	7
8	17	Information Systems - Other	Operating Expense	1,941,141	9	149,433		264,372	20,352	8
9	17	Admin Salaries	Direct Cost	1,290,832	9	615,798	615,798	175,808	83,870	9
10	17	Information Systems Salaries	Direct Cost	1,941,141	9	426,627	426,627	264,372	58,104	10
11	6	Information Systems - Equip Maint	Direct Cost	1,941,141	9	336,162		264,372	45,783	11
12	19	Admin Consulting,Other	Direct Cost	1,290,832	9	570,873		175,808	77,751	12
13	32	Admin - Interest Expense	Direct Cost	1,290,832	9	2,314,209		175,808	315,189	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		\$ 1,224,759	25

Facility Name & ID Number Provena St Anne Center

0041731

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		\$	\$		\$ 1,216,977	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 1,216,977	25

Facility Name & ID Number

Provena St Anne Center

0041731

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					\$	\$			\$ 287,243	1							
2											2							
3											3							
4											4							
5											5							
Working Capital																		
6											6							
7											7							
8											8							
9	TOTAL Facility Related					\$	\$			\$ 287,243	9							
B. Non-Facility Related*																		
10											10							
11											11							
12											12							
13											13							
14	TOTAL Non-Facility Related					\$	\$			\$	14							
15	TOTALS (line 9+line14)					\$	\$			\$ 287,243	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 St Anne Center

0041731

Report Period Beginning:

01/01/09

Ending:

12/31/09

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 70,000 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

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

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

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

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

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

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Nursing Home</u>		<u>1985</u>	<u>\$ 639,976</u>	<u>1</u>
2					<u>2</u>
3	TOTALS			\$ 639,976	3

Facility Name & ID Number Provena St Anne Center

0041731

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		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	120	1986	1986	\$ 3,516,907	\$ 100,483	35	\$ 100,483		\$ 2,439,731	4
5	59	1993	1993	2,722,251	90,742	30	90,742		1,488,930	5
6										6
7										7
8										8
	Improvement Type**									
9	Various		1990	34,784	1,122	31	1,122		21,880	9
10	Various		1992	471		10			471	10
11	Various		1993	1,623		10			1,623	11
12	Various		1994	5,000		10			5,000	12
13	Various		1995	40,225	1,271	10	1,271		25,821	13
14	Various		1996	11,192	535	18	535		10,390	14
15	Various		1997	41,546	892	12	892		39,315	15
16	Various		1998	25,080		5			25,080	16
17	Various		1999	6,269	30	5	30		6,269	17
18	Various		2000	27,288	571	5	571		27,003	18
19	Various		2001	283,276	18,849	5	18,849		191,721	19
20	Various		2002	11,068	586	6	586		7,437	20
21	Various		2003	38,963	3,066	10	3,066		25,436	21
22	Various		2004	48,430	5,120	9	5,120		30,844	22
23	Various		2005	34,969	2,145	8	2,145		12,656	23
24										24
25	DESC: REPLACE PIPING		2006	1,359	91	15	91		317	25
26	DESC: HOLLOW METAL FRAMES AND DOORS		2006	585	29	20	29		483	26
27	DESC: OPEN CEILING FOR SPRINKLER REPAIR AN		2006	1,000	200	5	200		700	27
28	DESC: REPLACE CEILING TILES IN MAIN DINING		2006	4,000	400	10	400		1,400	28
29	DESC: VINYL SIDING ON GARAGE AND SEAMLESS		2006	4,365	291	15	291		1,019	29
30	DESC: TILE IN 8 PATIENT ROOMS		2006	7,640	1,528	5	1,528		5,348	30
31	DESC: RUB RAILS		2006	2,051	205	10	205		718	31
32	DESC: WALK IN COOLER AND FREEZER / ROOFTOP		2006	30,100	2,007	15	2,007		7,023	32
33	DESC: TEKNOFLOR/VINYL BASE IN MAIN DINING		2006	22,100	2,210	10	2,210		7,735	33
34	DESC: REMOVE & REPAIR WATER DAMAGE AT SKY		2006	4,730	473	10	473		1,656	34
35	DESC: PAINTING ROOMS AND HALLWAYS		2006	9,922	1,984	5	1,984		5,953	35
36										36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Provena St Anne Center

0041731

Report Period Beginning:

01/01/09

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	DESC: REMODEL OF MAIN NURSES STATION	2007	\$ 12,500	\$ 833	15	\$ 833	\$	\$ 2,083	37
38	DESC: ELECTRICAL WORK	2007	9,609	961	10	961		2,402	38
39	DESC: (19) SUPPLY/RETURN GRILLES INTO NEW	2007	3,280	469	7	469		1,171	39
40	DESC: INSTALL ACOUSTICAL CEILINF & TILE FO	2007	36,500	3,650	10	3,650		9,125	40
41	DESC: SPRINKLER SYSTEM/ CONCRETE	2007	750	30	25	30		75	41
42	DESC: REPLACE FIRE SPRINKLER MAINS	2007	66,669	6,667	10	6,667		16,533	42
43	DESC: 10 TON ROOFTOP UNIT WITH GAS HEAT,EC	2007	11,889	793	15	793		1,982	43
44	DESC: VOICE ANNOUNCEMENT UNIT	2007	4,530	453	10	453		906	44
45	DESC: CABINETS AND COUNTERTOPS	2007	12,516	834	15	834		2,086	45
46	DESC: VINYL FLOORING & CARPET FOR LOBBY	2007	7,886	789	10	789		1,996	46
47	DESC: ELECTRICAL FOR KITCHEN EQUIP IN NEW	2007	6,376	425	15	425		850	47
48	DESC: BUILD 25 UNITS (ROOM DIVIDERS)	2007	19,250	1,925	10	1,925		3,850	48
49									49
50	DESC: ECO FRIENDLY GREEN HOUSE	2008	475	19	25	19		29	50
51	DESC: ROOF REPAIRS	2008	29,859	2,986	10	2,986		4,479	51
52	DESC: CAFE REMODEL	2008	765	77	10	77		115	52
53	DESC: MCQUAY PTAC UNITS	2008	10,900	727	15	727		1,090	53
54	DESC: (11) THERMO WINDOWS	2008	7,700	385	20	385		578	54
55	DESC: STAIN EXTERIOR BOARD AND TRIM	2008	3,650	521	7	521		782	55
56	DESC: INSTALLATION OF 10 AND SERVICE TO EX	2008	6,920	692	10	692		1,038	56
57	DESC: NURSE CALL SYSTEM	2008	61,170	6,117	10	6,117		9,176	57
58	DESC: FIRE DAMPERS	2008	4,101	410	10	410		615	58
59	DESC: SEALCOATING OF PARKING LOT	2008	2,781	348	8	348		521	59
60	DESC: CARESENSE CHAIR MONITORING SYSTEM/BE	2008	9,706	971	10	971		1,456	60
61									61
62	DESC: REPLACE CONTROL VALVES REPIPE DRAIN	2009	2,980	99	15	199	99	99	62
63	DESC: DOOR CLOSURE & SMOKE DETECTORS	2009	19,361	968	10	1,936	968	968	63
64	DESC: PARKING LOT REPAIRS/SEALCOATING	2009	14,252	1,018	7	2,036	1,018	1,018	64
65	DESC: UPGRADES TO ANSUL SYSTEM IN DIETARY	2009	3,334	167	10	333	167	167	65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 7,306,905	\$ 268,164		\$ 270,416	\$ 2,252	\$ 4,457,147	70

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

Facility Name & ID Number Provena St Anne Center

0041731

Report Period Beginning:

01/01/09

Ending:

12/31/09

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	\$ 1,124,710	\$ 115,676	\$ 115,676	\$	15	\$ 449,082	71
72	Current Year Purchases	173,749	10,008	20,016	10,008	10	10,008	72
73	Fully Depreciated Assets	308,703				10	302,235	73
74	Home Office Allocation		116,175	116,175				74
75	TOTALS	\$ 1,607,162	\$ 241,859	\$ 251,867	\$ 10,008		\$ 761,325	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Plant Engineering	1998 Minivan Chevy	1998	\$ 43,500	\$	\$	\$	5	\$ 43,500	76
77	Plant Engineering	1999 F150 Ford Truck	1999	23,172				3	23,172	77
78										78
79										79
80	TOTALS			\$ 66,672	\$	\$	\$		\$ 66,672	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 9,620,715	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 510,023	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 522,283	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 12,260	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 5,285,144	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				36,713			5
6								6
7	TOTAL				\$ 36,713			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: \$ 219,620 Description: Nursing \$176,106; Plant \$10,965; Admin \$27,974; Home Office \$4,575

(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	\$	10,999	\$	702,194	\$	10,999	\$	702,194	1		
2	Licensed Speech and Language Development Therapist	10a,3	hrs		1,347		86,734		1,347		86,734	2		
3	Licensed Recreational Therapist		hrs									3		
4	Licensed Physical Therapist	10a,3	hrs		12,256		784,269		12,256		784,269	4		
5	Physician Care		visits									5		
6	Dental Care		visits									6		
7	Work Related Program		hrs									7		
8	Habilitation		hrs									8		
9	Pharmacy	39,3	# of prescrpts					1,219,700			1,219,700	9		
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10		
11	Academic Education		hrs									11		
12	Other (specify):											12		
13	Other (specify):											13		
14	TOTAL			\$	24,602	\$	1,573,197	\$	1,219,700	\$	24,602	\$	2,792,897	14

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

Facility Name & ID Number **Provena St Anne Center**

0041731

Report Period Beginning: **01/01/09**

Ending: **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	3,804,179	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 72,065,085	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,006,945	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)	\$ 1,704,372	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 St Anne Center# 0041731Report 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	\$ 11,010,288	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 11,010,288	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,549,887	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,549,887	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	1,320	13
14	Non-Patient Meals	124,025	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,167,281	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	15,014	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,307,640	23
D. Non-Operating Revenue			
24	Contributions	29,393	24
25	Interest and Other Investment Income***	19,803	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 49,196	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Purchase Rebates</u>	539,571	28
28a	<u>Misc Income & Gain/Loss SOFA</u>	103,313	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 642,884	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 15,559,895	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,981,514	31
32	Health Care	7,055,490	32
33	General Administration	3,779,218	33
B. Capital Expense			
34	Ownership	421,748	34
C. Ancillary Expense			
35	Special Cost Centers	1,216,977	35
36	Provider Participation Fee	98,003	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 14,552,950	40
41	Income before Income Taxes (line 30 minus line 40)**	1,006,945	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,006,945	43

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

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

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

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

Facility Name & ID Number **Provena St Anne Center**

0041731

Report Period Beginning:

01/01/09

Ending:

12/31/09

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	1,536	1,752	\$ 77,232	\$ 44.08	1
2	Assistant Director of Nursing	1,884	2,080	64,282	30.90	2
3	Registered Nurses	31,518	33,842	1,012,120	29.91	3
4	Licensed Practical Nurses	56,802	61,213	1,536,674	25.10	4
5	CNAs & Orderlies	141,231	151,815	1,848,025	12.17	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	8,270	8,683	93,711	10.79	8
9	Activity Director	1,984	2,080	39,237	18.86	9
10	Activity Assistants	7,752	8,592	98,629	11.48	10
11	Social Service Workers	5,553	6,095	105,758	17.35	11
12	Dietician	2,304	2,624	69,676	26.55	12
13	Food Service Supervisor	4,008	4,355	58,022	13.32	13
14	Head Cook	8,896	9,520	112,768	11.85	14
15	Cook Helpers/Assistants	29,656	31,219	292,756	9.38	15
16	Dishwashers					16
17	Maintenance Workers	7,670	8,283	145,612	17.58	17
18	Housekeepers	14,935	16,256	151,066	9.29	18
19	Laundry	1,129	1,149	9,351	8.14	19
20	Administrator	1,868	2,080	118,303	56.88	20
21	Assistant Administrator	1,752	1,936	72,626	37.51	21
22	Other Administrative	7,864	8,313	226,452	27.24	22
23	Office Manager	1,904	2,080	43,242	20.79	23
24	Clerical	6,406	6,974	65,757	9.43	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>Pastoral</u>	2,201	2,441	47,449	19.44	33
34	TOTAL (lines 1 - 33)	347,123	373,382	\$ 6,288,748 *	\$ 16.84	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	560	\$ 35,829	1,3	35
36	Medical Director	\$1750/mo	21,000	9,3	36
37	Medical Records Consultant	36	2,488	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	50	2,895	11,3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	646	\$ 62,212		49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Janelle Chadwick	Administrator	0	\$ 118,303	Workers' Compensation Insurance	\$ 171,504	IDPH License Fee	\$	
Administrative Staff	Asst Administrator	0	72,626	Unemployment Compensation Insurance	42,418	Advertising: Employee Recruitment		
Administrative Staff	Office Manager	0	43,242	FICA Taxes	445,671	Health Care Worker Background Check		
Administrative Staff	Human Resources	0	45,203	Employee Health Insurance	667,299	(Indicate # of checks performed <u>101</u>)		
Administrative Staff	Receptionist	0	57,870	Employee Meals		Patient Background Checks	<u>610</u>	
Administrative Staff	Admin Asst	0	37,467	Illinois Municipal Retirement Fund (IMRF)*		Employee Recruitment	8,991	
Administrative Staff	Admissions	0	151,669	Life Insurance	28,421	Dues & Subscription	12,679	
TOTAL (agree to Schedule V, line 17, col. 1)				Pension	172,278	Advertising & Public Relations	26,769	
(List each licensed administrator separately.)			\$ 526,380	Employee Recognition	1,984			
B. Administrative - Other				Executive Benefits	7,874	Home Office Allocation	9,460	
Description			Amount	Employee Screening	21,146	Less: Public Relations Expense	()	
Corp Service Fee			\$ 175,808	Home Office Allocation	422,925	Non-allowable advertising	(22,440)	
Corp Service IS Fee			264,372			Yellow page advertising	(0)	
Mgmt Fee			617,022					
Mgmt Fee Interest			233,700	TOTAL (agree to Schedule V, line 22, col.8)	\$ 1,981,520	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 35,459	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 1,290,902	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
(Attach a copy of any management service agreement)				Description	Line #	Amount	Description	Amount
C. Professional Services				N/A			Out-of-State Travel	\$
Vendor/Payee	Type		Amount					
Legal Expense	Various		\$ 9,835					
Survey & Analytical Tools	Various		3,478					
Transporation Service	Various		4,537					
Collection Fees	Various		692				In-State Travel	10,600
Shredding/Storage	Various		1,132					
Living Design	Various		321					
Outsourced Services	Various		3,894				Seminar Expense	
Care Counselor	Various		11,545				Home Office Allocation	7,257
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			(agree to Sch. V, line 24, col. 8)	
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 35,434				TOTAL	\$ 17,857

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Provena St Anne Center

0041731

Report Period Beginning:

01/01/09

Ending:

12/31/09

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 \$9,059
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? Yes If YES, what is the capacity? 179
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 7 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 73,603 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 98,003
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. \$ 124,025
- (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
- (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.