



Facility Name & ID Number Provena St Joseph Center

# 0041871 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		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	120	TOTALS	120	43,800	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	23,066	10,535	5,554	39,155	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	23,066	10,535	5,554	39,155	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.39%

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

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

N/A - None

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

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

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

I. On what date did you start providing long term care at this location?  
Date started 7/1/1996

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 7/1/1996 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 120 and days of care provided 4,263

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 St Joseph Center # 0041871 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
	<b>A. General Services</b>										
1	Dietary	460,384	36,529	18,898	515,811		515,811		515,811		1
2	Food Purchase		195,484		195,484		195,484	(49,756)	145,728		2
3	Housekeeping	123,566	29,745		153,311		153,311		153,311		3
4	Laundry		1,978	109,307	111,285		111,285		111,285		4
5	Heat and Other Utilities			111,674	111,674		111,674	2,747	114,421		5
6	Maintenance	131,731	27,531	76,642	235,904		235,904	43,908	279,812		6
7	Other (specify):* <b>Pastoral Care</b>	50,908		38,719	89,627		89,627	(38,644)	50,983		7
8	<b>TOTAL General Services</b>	766,589	291,267	355,240	1,413,096		1,413,096	(41,745)	1,371,351		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			13,000	13,000		13,000		13,000		9
10	Nursing and Medical Records	2,235,053	146,993	23,510	2,405,556		2,405,556		2,405,556		10
10a	Therapy			494,587	494,587		494,587		494,587		10a
11	Activities	90,048	976	3,717	94,741		94,741	221	94,962		11
12	Social Services	22,612		671	23,283		23,283		23,283		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	2,347,713	147,969	535,485	3,031,167		3,031,167	221	3,031,388		16
	<b>C. General Administration</b>										
17	Administrative	251,954	22,536	741,148	1,015,638		1,015,638	(310,152)	705,486		17
18	Directors Fees										18
19	Professional Services			12,122	12,122		12,122	49,689	61,811		19
20	Dues, Fees, Subscriptions & Promotions			38,306	38,306		38,306	(15,138)	23,168		20
21	Clerical & General Office Expenses			46,913	46,913		46,913	6,442	53,355		21
22	Employee Benefits & Payroll Taxes			910,054	910,054		910,054	239,031	1,149,085		22
23	Inservice Training & Education			9,687	9,687		9,687	2,404	12,091		23
24	Travel and Seminar			4,903	4,903		4,903	4,237	9,140		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			105,456	105,456		105,456	(60)	105,396		26
27	Other (specify):* <b>Bad Debt</b>			(19,741)	(19,741)		(19,741)	19,741			27
28	<b>TOTAL General Administration</b>	251,954	22,536	1,848,848	2,123,338		2,123,338	(3,806)	2,119,532		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	3,366,256	461,772	2,739,573	6,567,601		6,567,601	(45,330)	6,522,271		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 &amp; ID Number

Provena St Joseph Center

#0041871

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	
	<b>D. Ownership</b>											
30	Depreciation			250,765	250,765		250,765	72,296	323,061			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							335,220	335,220			32
33	Real Estate Taxes			107,748	107,748		107,748		107,748			33
34	Rent-Facility & Grounds							21,436	21,436			34
35	Rent-Equipment & Vehicles			10,042	10,042		10,042	2,671	12,713			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			368,555	368,555		368,555	431,623	800,178			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			315,811	315,811		315,811	(254,944)	60,867			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			65,700	65,700		65,700		65,700			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			381,511	381,511		381,511	(254,944)	126,567			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,366,256	461,772	3,489,639	7,317,667		7,317,667	131,349	7,449,016			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	(51,829)	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	7,659	30		9
10	Interest and Other Investment Income	(7,494)	32		10
11	Discounts, Allowances, Rebates & Refunds	(254,944)	39		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	19,741	27		24
25	Fund Raising, Advertising and Promotional	(20,662)	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	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (307,529)		\$	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)	477,522		34
35	Other- Attach Schedule	(38,644)		35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 438,878		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ 131,349		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY							
48		49		50		51	52

Provena St Joseph Center

ID# 0041871

Report Period Beginning: 01/01/09

Ending: 12/31/09

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	Development Misc	\$ (38,644)	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	<b>Total</b>	(38,644)	49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Provena St Joseph Center# 0041871

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	(51,829)	2,073	0	0	0	0	0	0	0	0	0	(49,756)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	2,747	0	0	0	0	0	0	0	0	0	2,747	5
6	Maintenance	0	740	43,168	0	0	0	0	0	0	0	0	43,908	6
7	Other (specify):*	(38,644)	0	0	0	0	0	0	0	0	0	0	(38,644)	7
8	<b>TOTAL General Services</b>	<b>(90,473)</b>	<b>5,560</b>	<b>43,168</b>	<b>0</b>	<b>(41,745)</b>	<b>8</b>							
	<b>B. Health Care and Programs</b>													
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	221	0	0	0	0	0	0	0	0	0	221	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	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>221</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>221</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	(293,961)	(16,191)	0	0	0	0	0	0	0	0	(310,152)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	31,273	18,416	0	0	0	0	0	0	0	0	49,689	19
20	Fees, Subscriptions & Promotions	(20,662)	5,524	0	0	0	0	0	0	0	0	0	(15,138)	20
21	Clerical & General Office Expenses	0	6,442	0	0	0	0	0	0	0	0	0	6,442	21
22	Employee Benefits & Payroll Taxes	0	85,695	153,336	0	0	0	0	0	0	0	0	239,031	22
23	Inservice Training & Education	0	2,404	0	0	0	0	0	0	0	0	0	2,404	23
24	Travel and Seminar	0	4,237	0	0	0	0	0	0	0	0	0	4,237	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	(60)	0	0	0	0	0	0	0	0	0	(60)	26
27	Other (specify):*	19,741	0	0	0	0	0	0	0	0	0	0	19,741	27
28	<b>TOTAL General Administration</b>	<b>(921)</b>	<b>(158,446)</b>	<b>155,561</b>	<b>0</b>	<b>(3,806)</b>	<b>28</b>							
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(91,394)</b>	<b>(152,665)</b>	<b>198,729</b>	<b>0</b>	<b>(45,330)</b>	<b>29</b>							

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Provena St Joseph Center# 0041871

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)	
	<b>D. Ownership</b>													
30	Depreciation	7,659	0	64,637	0	0	0	0	0	0	0	0	72,296	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(7,494)	0	342,714	0	0	0	0	0	0	0	0	335,220	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	21,436	0	0	0	0	0	0	0	0	21,436	34
35	Rent-Equipment & Vehicles	0	0	2,671	0	0	0	0	0	0	0	0	2,671	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>165</b>	<b>0</b>	<b>431,458</b>	<b>0</b>	<b>431,623</b>	<b>37</b>							
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	(254,944)	0	0	0	0	0	0	0	0	0	0	(254,944)	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	<b>TOTAL Special Cost Centers</b>	<b>(254,944)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(254,944)</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	(sum of lines 29, 37 & 44)	(346,173)	(152,665)	630,187	0	0	0	0	0	0	0	0	131,349	45

Facility Name & ID Number

Provena St Joseph Center

# 0041871

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%	\$ 2,073	\$ 2,073	1
2	V	5 Utilities		Provena Senior Services	100.00%	2,747	2,747	2
3	V	6 Maintenance - Other		Provena Senior Services	100.00%	740	740	3
4	V	11 Activities-Special Events		Provena Senior Services	100.00%	221	221	4
5	V	17 Admin - Misc. Other		Provena Senior Services	100.00%	5,677	5,677	5
6	V	17 Administrative Salaries	496,728	Provena Senior Services	100.00%	197,090	(299,638)	6
7	V	19 Professional Services		Provena Senior Services	100.00%	31,273	31,273	7
8	V	20 Dues,Subscriptions		Provena Senior Services	100.00%	5,524	5,524	8
9	V	21 Clerical Supplies		Provena Senior Services	100.00%	6,442	6,442	9
10	V	22 Employee Benefits		Provena Senior Services	100.00%	85,695	85,695	10
11	V	23 Education/Conference		Provena Senior Services	100.00%	2,404	2,404	11
12	V	24 Travel		Provena Senior Services	100.00%	4,237	4,237	12
13	V	26 Insurance		Provena Senior Services	100.00%	(60)	(60)	13
14	Total		\$ 496,728			\$ 344,063	\$ * (152,665)	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%	\$ 2,763	\$ 2,763
16	V	32 Interest		Provena Senior Services	100.00%	167,718	167,718
17	V	34 Rent - Facility		Provena Senior Services	100.00%	21,436	21,436
18	V	35 Rent - Equipment		Provena Senior Services	100.00%	2,671	2,671
19	V	17 Admin Salaries	97,610	Provena Health Services	100.00%	81,792	(15,818)
20	V	22 Employee Benefits		Provena Health Services	100.00%	52,272	52,272
21	V	30 Depreciation		Provena Health Services	100.00%	61,874	61,874
22	V	19 Admin Consulting, Other		Provena Health Services	100.00%	18,416	18,416
23	V	17 Information Systems Salaries	146,810	Provena Health Services	100.00%	77,889	(68,921)
24	V	22 Information Systems Benefits		Provena Health Services	100.00%	29,075	29,075
25	V	17 Information Systems - Other		Provena Health Services	100.00%	24,980	24,980
26	V	17 Admin Salaries		Provena Health Services	100.00%	11,302	11,302
27	V	22 Employee Benefits		Provena Health Services	100.00%	46,565	46,565
28	V	17 Information Systems Salaries		Provena Health Services	100.00%	32,266	32,266
29	V	22 Information Systems Benefits		Provena Health Services	100.00%	25,424	25,424
30	V	6 Information Systems - Equip Maint		Provena Health Services	100.00%	43,168	43,168
31	V	32 Admin - Interest Expense		Provena Health Services	100.00%	174,996	174,996
32	V	39 Ancillary Services - Other	315,811	Provena Senior Services Pharmacy	100.00%	315,811	
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 560,231			\$ 1,190,418	\$ * 630,187

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

Facility Name &amp; ID Number

Provena St Joseph Center

# 0041871

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 Joseph Center

# 0041871

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	\$ 496,728	\$ 2,073	1	
2	5	Utilities	Management Fee Income	6,810,879	19	37,672	496,728	2,747	2	
3	6	Maintenance - Other	Management Fee Income	6,810,879	19	10,148	496,728	740	3	
4	11	Activities-Special Events	Management Fee Income	6,810,879	19	3,032	496,728	221	4	
5	17	Admin - Misc. Other	Management Fee Income	6,810,879	19	77,835	496,728	5,677	5	
6	17	Administrative Salaries	Management Fee Income	6,810,879	19	2,702,403	2,702,403	496,728	197,090	6
7	19	Professional Services	Management Fee Income	6,810,879	19	428,802	496,728	31,273	7	
8	20	Dues,Subscriptions	Management Fee Income	6,810,879	19	75,736	496,728	5,524	8	
9	21	Clerical Supplies	Management Fee Income	6,810,879	19	88,333	496,728	6,442	9	
10	22	Employee Benefits	Management Fee Income	6,810,879	19	1,175,007	496,728	85,695	10	
11	23	Education/Conference	Management Fee Income	6,810,879	19	32,966	496,728	2,404	11	
12	24	Travel	Management Fee Income	6,810,879	19	58,096	496,728	4,237	12	
13	26	Insurance	Management Fee Income	6,810,879	19	(818)	496,728	(60)	13	
14	30	Depreciation	Management Fee Income	6,810,879	19	37,881	496,728	2,763	14	
15	32	Interest	Management Fee Income	6,810,879	19	2,299,667	496,728	167,718	15	
16	34	Rent - Facility	Management Fee Income	6,810,879	19	293,923	496,728	21,436	16	
17	35	Rent - Equipment	Management Fee Income	6,810,879	19	36,626	496,728	2,671	17	
18									18	
19									19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 7,385,732	\$ 2,702,403	\$ 538,651	25	

Facility Name & ID Number Provena St Joseph Center

# 0041871

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	97,610	\$ 81,792	1
2	22	Employee Benefits	Operating Expense	1,290,832	9	691,262		97,610	52,272	2
3	30	Depreciation	Operating Expense	1,290,832	9	818,246		97,610	61,874	3
4	34	Rent Facility	Operating Expense	1,290,832	9	243,546		97,610	18,416	4
5	19	Admin Consulting,Other	Operating Expense	1,290,832	9	1,030,040		97,610	77,889	5
6	17	Information Systems Salaries	Operating Expense	1,941,141	9	384,433	384,433	146,810	29,075	6
7	22	Information Systems Benefits	Operating Expense	1,941,141	9	330,293		146,810	24,980	7
8	17	Information Systems - Other	Operating Expense	1,941,141	9	149,433		146,810	11,302	8
9	17	Admin Salaries	Direct Cost	1,290,832	9	615,798	615,798	97,610	46,565	9
10	17	Information Systems Salaries	Direct Cost	1,941,141	9	426,627	426,627	146,810	32,266	10
11	6	Information Systems - Equip Maint	Direct Cost	1,941,141	9	336,162		146,810	25,424	11
12	19	Admin Consulting,Other	Direct Cost	1,290,832	9	570,873		97,610	43,168	12
13	32	Admin - Interest Expense	Direct Cost	1,290,832	9	2,314,209		97,610	174,996	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		\$ 680,019	25

Facility Name & ID Number Provena St Joseph Center

# 0041871

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		\$	\$		\$ 315,811	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				\$	\$		\$ 315,811	25

Facility Name & ID Number

Provena St Joseph Center

# 0041871

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
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1	Home Office Allocation					\$	\$			\$ 167,718	1							
2											2							
3											3							
4											4							
5											5							
<b>Working Capital</b>																		
6											6							
7											7							
8											8							
9	<b>TOTAL Facility Related</b>					\$	\$			\$ 167,718	9							
<b>B. Non-Facility Related*</b>																		
10											10							
11											11							
12											12							
13											13							
14	<b>TOTAL Non-Facility Related</b>					\$	\$			\$	14							
15	<b>TOTALS (line 9+line14)</b>					\$	\$			\$ 167,718	15							

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

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

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

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

**B. Real Estate Taxes**

**Important**, please see the next worksheet, "RE\_Tax". The real estate tax statement and

1. Real Estate Tax accrual used on 2008 report.		\$	<b>1</b>
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	<b>2</b>
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>3</b>
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>107,748</b> <b>4</b>
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	<b>5</b>
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	<b>6</b>
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>107,748</b> <b>7</b>
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2004	_____	<b>8</b>
	2005	_____	<b>9</b>
	2006	_____	<b>10</b>
	2007	_____	<b>11</b>
	2008	_____	<b>12</b>
			<b>FOR BHF USE ONLY</b>
	<b>13</b>	FROM R. E. TAX STATEMENT FOR 2008 \$	<b>13</b>
	<b>14</b>	PLUS APPEAL COST FROM LINE 5 \$	<b>14</b>
	<b>15</b>	LESS REFUND FROM LINE 6 \$	<b>15</b>
	<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION \$	<b>16</b>

**NOTES:**

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



Facility Name & ID Number Provena St Joseph Center

# 0041871

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**X. BUILDING AND GENERAL INFORMATION:**

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

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

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

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

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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>1996</u>	<u>\$ 1,400,000</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>			<b>\$ 1,400,000</b>	<b>3</b>

Facility Name &amp; ID Number Provena St Joseph Center

# 0041871

Report Period Beginning:

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**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	120		1996	1996	\$ 2,500,000	\$ 62,500	40	\$ 62,500	\$	\$ 843,750	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	Various		1997		24,718	1,135	8	1,135		21,880	9
10	Various		1998		3,718		7			3,718	10
11	Various		1999		78,698	3,935	11	3,935		57,543	11
12	Various		2000		9,480		5			9,480	12
13	Various		2001		25,584	827	8	827		21,721	13
14	Various		2002		47,439	2,235	10	2,235		36,674	14
15	Various		2003		76,557	7,218	11	7,218		47,146	15
16	Various		2004		32,239	3,168	11	3,168		24,822	16
17	Various		2005		98,930	11,699	15	11,699		34,434	17
18											18
19	DESC: PATCH CEILINGS IN HALLWAY		2006		800	80	10	80		280	19
20	DESC: TRINITY HOUSE CARPETING		2006		1,741	348	5	348		1,219	20
21	DESC: TREE REMOVAL		2006		2,500	500	5	500		1,750	21
22	DESC: LANDSCAPING - REMOVAL OF 23 STUMPS		2006		800	80	10	80		280	22
23	DESC: SEWER LINE FROM HOUSE TO MAN HOLE -		2006		116	19	3	19		116	23
24	DESC: REPAIR LOADING DOCK AREA		2006		3,664	458	8	458		1,603	24
25	DESC: LANDSCAPING		2006		12,910	1,291	10	1,291		2,741	25
26	DESC: FLOORING FOR KITCHENETTE, 2 NURSES S		2006		2,595	519	5	519		1,817	26
27	DESC: RECOVER 2 L SHAPED AWNINGS		2006		2,380	238	10	238		833	27
28	DESC: SIDEWALK REPLACEMENT		2006		2,596	173	15	173		544	28
29	DESC: HIGH EFFICIENCY FURNACE		2006		7,125	475	15	475		1,663	29
30	DESC: FIRE SPRINKLER		2006		7,155	477	15	477		1,637	30
31	DESC: RENOVATION OF CHAPEL		2006		20,000	1,333	15	1,333		3,619	31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

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# 0041871

Report Period Beginning:

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## 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: CULTURE CHANGE	2007	\$ 13,650	\$ 1,365	10	\$ 1,365	\$	\$ 3,047	37
38	DESC: PAINTING OF NURSING HOME	2007	6,264	1,253	5	1,253		3,132	38
39	DESC: DINING ROOM PAINTING	2007	9,075	1,815	5	1,815		4,538	39
40	DESC: REWIRING OF ELECTRICAL FOR HOBAN HAL	2007	15,690	785	20	785		1,961	40
41	DESC: ENTRANCE CANOPY	2007	665	67	10	67		166	41
42	DESC: PT/OT REMODELING	2007	33,243	2,216	15	2,216		4,611	42
43	DESC: LOBBY REMODEL	2007	24,214	1,614	15	1,614		4,036	43
44	DESC: WIRING FOR FIRE ALARMS / TIE INTO NE	2007	46,500	2,325	20	2,325		4,650	44
45	DESC: ENTRANCE CANOPY / DRIVE	2007	3,568	357	10	357		714	45
46	DESC: ACCUTECH WANDERING AND VOICE ANNOUNC	2007	27,827	2,783	10	2,783		6,957	46
47									47
48	DESC: ELECTRICAL WORK FOR MINISTRY	2008	8,100	405	20	405		608	48
49	DESC: REMODEL OF CHURCH	2008	42,100	2,105	20	2,105		3,158	49
50	DESC: NEW BASEBOARD COVERS FOR 64 RESIDENT	2008	21,020	2,102	10	2,102		3,153	50
51	DESC: REMODEL OF DINING ROOM	2008	9,030	753	12	753		1,129	51
52	DESC: FLAG POLE	2008	3,785	189	20	189		284	52
53	DESC: WINDOWS FOR CLF 1ST FLOOR	2008	3,424	342	10	342		514	53
54	DESC: MOBILE CABINET	2008	2,135	213	10	213		320	54
55	DESC: PARKING LOT REPAIRS, CONCRETE WALKWA	2008	74,818	9,352	8	9,352		14,028	55
56	DESC: CANOPY PROJECT	2008	4,868	325	15	325		487	56
57	DESC: DEPRECIATION FOR FIN 47 ASSETS	2008		1,616		1,616		6,461	57
58								105	58
59	DESC: SPRINKLER REPAIRS	2009	4,185	105	20	209	104	224	59
60	DESC: COMPRESSOR REPAIRS	2009	5,365	224	12	447	224	1,140	60
61	DESC: CANOPY PROJECT	2009	34,200	1,140	15	2,280	1,140	337	61
62	DESC: ASPHALT PARKING LOT	2009	5,396	337	8	675	337	2,791	62
63	DESC: HOT WATER EXCHANGER, EXPANSION TANK,	2009	55,826	2,791	10	5,583	2,791	772	63
64	DESC: 15 SECOND DOOR MAGNETS, TRANSMITTERS	2009	15,440	772	10	1,544	772	265	64
65	DESC: GENERATOR LOAD	2009	2,649	265	5	530	265	220	65
66	DESC: CARRIER 10 TON CONDENSING UNIT W/ LO	2009	6,590	220	15	439	220	880	66
67	DESC: REMODEL THIRD FLOOR MEN'S BATHROOM	2009	17,605	880	10	1,760	880		67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,458,976	\$ 137,423		\$ 144,156	\$ 6,733	\$ 1,189,954	70

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

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# 0041871

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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	\$ 1,053,923	\$ 108,504	\$ 108,504	\$	10	\$ 365,556	71
72	Current Year Purchases	14,946	926	1,852	926	11	926	72
73	Fully Depreciated Assets	470,751				5	470,751	73
74	Home Office Allocation		64,637	64,637				74
75	TOTALS	\$ 1,539,620	\$ 174,067	\$ 174,993	\$ 926		\$ 837,234	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Plant Engineering	1997 Dodge 2500	1997	\$ 24,090	\$	\$	\$	5	\$ 24,090	76
77	Plant Engineering	2001 Mercury Sable	2001	23,123				3	23,123	77
78	Plant Engineering	2003 Ford Van	2004	34,275				4	34,275	78
79	Plant Engineering	2006 Chevy Uplander	2007	15,649	3,912	3,912		4	9,780	79
80	TOTALS			\$ 97,137	\$ 3,912	\$ 3,912	\$		\$ 91,268	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 6,495,732	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 315,402	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 323,061	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 7,659	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,118,456	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				21,436			5
6								6
7	TOTAL				\$ 21,436			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: \$ 21,029 Description: Nursing \$8,516; Administration \$9,842; Home Office \$2,671

(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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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)	
<b>TOTAL TRAINED</b>	

- (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	\$	3,424	\$ 218,557	\$	3,424	\$ 218,557	1	
2	Licensed Speech and Language Development Therapist	10a,3	hrs		174	11,215		174	11,215	2	
3	Licensed Recreational Therapist		hrs							3	
4	Licensed Physical Therapist	10a,3	hrs		4,138	264,815		4,138	264,815	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				316,375		316,375	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	<b>TOTAL</b>			\$	7,736	\$ 494,587	\$ 316,375	7,736	\$ 810,962	14	

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

Facility Name & ID Number **Provena St Joseph Center**# **0041871**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 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
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	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 25,819,261	\$	10
<b>B. Long-Term Assets</b>				
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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 62,558,520	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 88,377,781	\$	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
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
<b>Other Current Liabilities(specify):</b>				
36	<u>Due to Related Party</u>	913,853		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 12,617,399	\$	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable	1,170,110		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	382,071		42
<b>Other Long-Term Liabilities(specify):</b>				
43	<u>Conditional Asset Retirement</u>	438,744		43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 1,990,925	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 14,608,324	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 73,769,457	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 88,377,781	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b>	
		<b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>73,629,105</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Transfer to Affiliates</b>	<b>(5,368,199)</b>	<b>3</b>
<b>4</b>	<b>Adj. To reconcile consolidated equity &amp; consolidated income</b>	<b>2,883,450</b>	<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>71,144,356</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>1,927,674</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants	<b>857,343</b>	<b>11</b>
<b>12</b>	Expenditures for Specific Purposes	<b>(159,916)</b>	<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>2,625,101</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>73,769,457</b>	<b>24</b> *

\* This must agree with page 17, line 47.

Facility Name & ID Number Provena St Joseph Center# 0041871Report 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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 5,854,131	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 5,854,131	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	780,398	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 780,398	8
<b>C. Other Operating Revenue</b>			
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	396	13
14	Non-Patient Meals	51,829	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	264,479	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 316,704	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	2,051,547	24
25	Interest and Other Investment Income***	7,494	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 2,059,041	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Purchase Rebates</u>	254,944	28
28a	<u>Misc Income &amp; Gain/Loss SOFA</u>	(19,877)	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 235,067	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 9,245,341	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,413,096	31
32	Health Care	3,031,167	32
33	General Administration	2,123,338	33
<b>B. Capital Expense</b>			
34	Ownership	368,555	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	315,811	35
36	Provider Participation Fee	65,700	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 7,317,667	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	1,927,674	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 1,927,674	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 Joseph Center**

# **0041871**

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	1,904	2,080	\$ 84,416	\$ 40.58	1
2	Assistant Director of Nursing	1,780	2,080	70,188	33.74	2
3	Registered Nurses	10,936	11,734	333,842	28.45	3
4	Licensed Practical Nurses	29,131	31,206	615,586	19.73	4
5	CNAs & Orderlies	82,173	88,350	1,057,705	11.97	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,487	6,283	73,318	11.67	8
9	Activity Director	1,788	2,080	29,628	14.24	9
10	Activity Assistants	5,867	6,336	60,420	9.54	10
11	Social Service Workers	1,860	2,080	22,612	10.87	11
12	Dietician	1,968	2,208	46,747	21.17	12
13	Food Service Supervisor					13
14	Head Cook	5,990	6,673	74,745	11.20	14
15	Cook Helpers/Assistants	35,296	37,971	338,891	8.92	15
16	Dishwashers					16
17	Maintenance Workers	9,187	9,759	131,731	13.50	17
18	Housekeepers	12,711	14,174	123,565	8.72	18
19	Laundry					19
20	Administrator	1,224	1,600	79,779	49.86	20
21	Assistant Administrator	688	704	29,914	42.49	21
22	Other Administrative	5,507	6,224	94,779	15.23	22
23	Office Manager					23
24	Clerical	4,547	4,793	47,482	9.91	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>	1,908	2,080	50,908	24.48	33
34	TOTAL (lines 1 - 33)	219,952	238,415	\$ 3,366,256 *	\$ 14.12	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	245	\$ 17,390	1,3	35
36	Medical Director	\$1000/mo	13,000	9,3	36
37	Medical Records Consultant	32	2,279	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	10	1,152	11,3	44
45	Social Service Consultant	4	671	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	291	\$ 34,492		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	
Michelle Lindeman	Administrator	0	\$ 79,779	Workers' Compensation Insurance	\$ 95,196	IDPH License Fee	\$	
Administrative Staff	Asst. Administrator	0	29,914	Unemployment Compensation Insurance	24,267	Advertising: Employee Recruitment		
Administrative Staff	Bookkeeper	0	36,022	FICA Taxes	241,959	Health Care Worker Background Check		
Administrative Staff	Admissions	0	16,951	Employee Health Insurance	393,370	(Indicate # of checks performed <u>46</u> )		
Administrative Staff	Receptionist	0	47,317	Employee Meals		Patient Background Checks	<u>125</u>	
Administrative Staff	Admini Asst	0	0	Illinois Municipal Retirement Fund (IMRF)*		Employee Recruitment	2,434	
Administrative Staff	Human Resources	0	41,971	Life Insurance	13,850	Dues & Subscriptions	14,372	
TOTAL (agree to Schedule V, line 17, col. 1)				Pension	117,805	Advertising & Public Relations	21,500	
(List each licensed administrator separately.)			\$ 251,954	Employee Recognition	882			
B. Administrative - Other				Executive Benefits	6,881	Home Office Allocation	5,524	
Description			Amount	Employee Screenings	15,844	Less: Public Relations Expense	( )	
Corp Service Fee			\$ 97,610	Home Office Allocation	239,031	Non-allowable advertising	(20,662)	
Corp Service IS Fee			146,810			Yellow page advertising	( )	
Mgmt Fee			342,528					
Mgmt Fee Interest			154,200					
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 741,148	TOTAL (agree to Schedule V, line 22, col.8)	\$ 1,149,085	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 23,168	
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
C. Professional Services				Description	Line #	Amount	Description	Amount
Vendor/Payee	Type		Amount	N/A		\$	Out-of-State Travel	\$
Survey & Analytical Tools	Various		\$ 1,540					
Outsourced Services	Various		1,238					
Living Design	Various		1,202					
Care Counselor	Various		4,641				In-State Travel	4,903
Anthing Aquatic	Various		2,353					
Legal	Various		1,148				Seminar Expense	
							Home Office Allocation	4,237
							Entertainment Expense	( )
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ 9,140
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 12,122					

\* Attach copy of IMRF notifications

\*\*See instructions.



Facility Name &amp; ID Number Provena St Joseph Center

# 0041871

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 \$5,516
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? Yes If YES, what is the capacity? 120
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 7 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 39,639 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 65,700  
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. \$ 51,829
- (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.