FOR BHF USE

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2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0042879

Facility Name: Provena McAuley Manor

Address: 400 West Sullivan Road (Number) Aurora (City) 60506 (Zip Code)

County: Kane

Telephone Number: (630) 859-3700 **Fax #** (630) 264-1862

HFS ID Number:

Date of Initial License for Current Owners: 12/01/97

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code	501 C3		Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Lynda Olinski **Telephone Number:** 708-478-7916
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2010 to 12/31/2010 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name) Michael R. Gordon
(Title) CFO, VP of Finance

Paid Preparer
(Signed) (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Provena McAuley Manor # 0042879 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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 08/06/2010

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	87	Skilled (SNF)	87	31,755	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	87	TOTALS	87	31,755	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,786	9,342	12,028	23,156	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	1,786	9,342	12,028	23,156	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 72.92%

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 [X]

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

I. On what date did you start providing long term care at this location?
Date started 12/1/1997

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 87 and days of care provided 10,002

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/10 Fiscal Year: 12/31/10

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

Facility Name & ID Number Provena McAuley Manor # 0042879 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	212,109	37,382	9,631	259,122		259,122		259,122			1
2	Food Purchase		147,377		147,377		147,377	(7,049)	140,328			2
3	Housekeeping	138,871	26,785		165,656		165,656		165,656			3
4	Laundry	25,995	2,905	61,048	89,948		89,948		89,948			4
5	Heat and Other Utilities			123,041	123,041		123,041	5,145	128,186			5
6	Maintenance	86,252	32,852	73,564	192,668		192,668	49,457	242,125			6
7	Other (specify):* Pastoral	35,965	2,136	45,326	83,427		83,427	(27,136)	56,291			7
8	TOTAL General Services	499,192	249,437	312,610	1,061,239		1,061,239	20,417	1,081,656			8
	B. Health Care and Programs											
9	Medical Director			30,000	30,000		30,000		30,000			9
10	Nursing and Medical Records	2,364,838	245,322	46,141	2,656,301		2,656,301		2,656,301			10
10a	Therapy			865,824	865,824		865,824		865,824			10a
11	Activities	62,913	3,294	17,037	83,244		83,244	172	83,416			11
12	Social Services	49,085	56	1,986	51,127		51,127		51,127			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,476,836	248,672	960,988	3,686,496		3,686,496	172	3,686,668			16
	C. General Administration											
17	Administrative	339,527	24,280	712,986	1,076,793		1,076,793	(195,611)	881,182			17
18	Directors Fees											18
19	Professional Services			13,708	13,708		13,708	(59,361)	(45,653)			19
20	Dues, Fees, Subscriptions & Promotions			44,616	44,616		44,616	(25,442)	19,174			20
21	Clerical & General Office Expenses			42,824	42,824		42,824	5,151	47,975			21
22	Employee Benefits & Payroll Taxes			768,202	768,202		768,202	202,613	970,815			22
23	Inservice Training & Education			2,391	2,391		2,391	318	2,709			23
24	Travel and Seminar			1,914	1,914		1,914	2,930	4,844			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			123,296	123,296		123,296	(417)	122,879			26
27	Other (specify):* Bad Debt			59,971	59,971		59,971	(59,971)				27
28	TOTAL General Administration	339,527	24,280	1,769,908	2,133,715		2,133,715	(129,790)	2,003,925			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,315,555	522,389	3,043,506	6,881,450		6,881,450	(109,201)	6,772,249			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 McAuley Manor #0042879 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			342,305	342,305		342,305	80,417	422,722			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							388,330	388,330			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds							16,525	16,525			34
35	Rent-Equipment & Vehicles			9,085	9,085		9,085	2,114	11,199			35
36	Other (specify):*											36
37	**TOTAL Ownership**			351,390	351,390		351,390	487,386	838,776			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			779,938	779,938		779,938	(258,196)	521,742			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			47,763	47,763		47,763		47,763			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			827,701	827,701		827,701	(258,196)	569,505			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,315,555	522,389	4,222,597	8,060,541		8,060,541	119,989	8,180,530			45

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

Facility Name & ID Number Provena McAuley Manor # 0042879 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(9,145)	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	15,102	30		9
10	Interest and Other Investment Income	(6,674)	32		10
11	Discounts, Allowances, Rebates & Refunds	(258,196)	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	(59,971)	27		24
25	Fund Raising, Advertising and Promotional	(29,590)	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)**	$ (348,474)		$	30

BHF USE ONLY									
48		49		50		51		52	

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 Amount	2 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)	495,599		34
35	Other- Attach Schedule	(27,136)		35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 468,463		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 119,989		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 Yes	2 No	3 Amount	4 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

Provena McAuley Manor

ID# 0042879

Report Period Beginning: 1/1/2010

Ending: 12/31/2010

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Development Postage	$ (6)	7	1
2	Development Misc	(27,130)	7	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(27,136)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Provena McAuley Manor # 0042879 **Report Period Beginning:** 1/1/2010 **Ending:** 12/31/2010

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	(9,145)	2,096	0	0	0	0	0	0	0	0	0	(7,049)	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	5,145	0	0	0	0	0	0	0	0	0	5,145	5
6	Maintenance	0	964	48,493	0	0	0	0	0	0	0	0	49,457	6
7	Other (specify):*	(27,136)	0	0	0	0	0	0	0	0	0	0	(27,136)	7
8	**TOTAL General Services**	(36,281)	8,205	48,493	0	0	0	0	0	0	0	0	20,417	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	172	0	0	0	0	0	0	0	0	0	172	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	172	0	0	0	0	0	0	0	0	0	172	16
	C. General Administration													
17	Administrative	0	(292,496)	96,885	0	0	0	0	0	0	0	0	(195,611)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	11,003	(70,364)	0	0	0	0	0	0	0	0	(59,361)	19
20	Fees, Subscriptions & Promotions	(29,590)	4,148	0	0	0	0	0	0	0	0	0	(25,442)	20
21	Clerical & General Office Expenses	0	5,151	0	0	0	0	0	0	0	0	0	5,151	21
22	Employee Benefits & Payroll Taxes	0	48,576	154,037	0	0	0	0	0	0	0	0	202,613	22
23	Inservice Training & Education	0	318	0	0	0	0	0	0	0	0	0	318	23
24	Travel and Seminar	0	2,930	0	0	0	0	0	0	0	0	0	2,930	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	(417)	0	0	0	0	0	0	0	0	0	(417)	26
27	Other (specify):*	(59,971)	0	0	0	0	0	0	0	0	0	0	(59,971)	27
28	**TOTAL General Administration**	(89,561)	(220,787)	180,558	0	0	0	0	0	0	0	0	(129,790)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(125,842)	(212,410)	229,051	0	0	0	0	0	0	0	0	(109,201)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Provena McAuley Manor # 0042879 **Report Period Beginning:** 1/1/2010 **Ending:** 12/31/2010

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	15,102	0	65,315	0	0	0	0	0	0	0	0	80,417	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(6,674)	0	395,004	0	0	0	0	0	0	0	0	388,330	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	16,525	0	0	0	0	0	0	0	0	16,525	34
35	Rent-Equipment & Vehicles	0	0	2,114	0	0	0	0	0	0	0	0	2,114	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	8,428	0	478,958	0	0	0	0	0	0	0	0	487,386	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	(258,196)	0	0	0	0	0	0	0	0	0	0	(258,196)	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**	(258,196)	0	0	0	0	0	0	0	0	0	0	(258,196)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(375,610)	(212,410)	708,009	0	0	0	0	0	0	0	0	119,989	45

Facility Name & ID Number Provena McAuley Manor # 0042879 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	2	Food	$	Provena Senior Services	100.00%	$ 2,096	$ 2,096	1
2	V	5	Utilities		Provena Senior Services	100.00%	5,145	5,145	2
3	V	6	Maintenance - Other		Provena Senior Services	100.00%	964	964	3
4	V	11	Activities-Special Events		Provena Senior Services	100.00%	172	172	4
5	V	17	Admin - Misc. Other		Provena Senior Services	100.00%	3,759	3,759	5
6	V	17	Administrative Salaries	492,408	Provena Senior Services	100.00%	196,153	(296,255)	6
7	V	19	Professional Services		Provena Senior Services	100.00%	11,003	11,003	7
8	V	20	Dues,Subscriptions		Provena Senior Services	100.00%	4,148	4,148	8
9	V	21	Clerical Supplies		Provena Senior Services	100.00%	5,151	5,151	9
10	V	22	Employee Benefits		Provena Senior Services	100.00%	48,576	48,576	10
11	V	23	Education/Conference		Provena Senior Services	100.00%	318	318	11
12	V	24	Travel		Provena Senior Services	100.00%	2,930	2,930	12
13	V	26	Insurance		Provena Senior Services	100.00%	(417)	(417)	13
14	Total			$ 492,408			$ 279,998	$ * (212,410)	14

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

Facility Name & ID Number Provena McAuley Manor # 0042879 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	30	Depreciation	$	Provena Senior Services	100.00%	$ 2,605	$ 2,605	15
16	V	32	Interest		Provena Senior Services	100.00%	215,862	215,862	16
17	V	34	Rent - Facility		Provena Senior Services	100.00%	16,525	16,525	17
18	V	35	Rent - Equipment		Provena Senior Services	100.00%	2,114	2,114	18
19	V	17	Admin Salaries		Provena Health Services	100.00%	76,901	76,901	19
20	V	22	Employee Benefits		Provena Health Services	100.00%	52,738	52,738	20
21	V	30	Depreciation		Provena Health Services	100.00%	62,710	62,710	21
22	V	19	Admin Consulting,Other	90,325	Provena Health Services	100.00%	19,961	(70,364)	22
23	V	17	Information Systems Salaries		Provena Health Services	100.00%	80,011	80,011	23
24	V	22	Information Systems Benefits		Provena Health Services	100.00%	27,643	27,643	24
25	V	17	Information Systems - Other	130,253	Provena Health Services	100.00%	25,740	(104,513)	25
26	V	17	Admin Salaries		Provena Health Services	100.00%	11,960	11,960	26
27	V	22	Employee Benefits		Provena Health Services	100.00%	46,374	46,374	27
28	V	17	Information Systems Salaries		Provena Health Services	100.00%	32,526	32,526	28
29	V	22	Information Systems Benefits		Provena Health Services	100.00%	27,282	27,282	29
30	V	6	Information Systems - Equip Maint		Provena Health Services	100.00%	48,493	48,493	30
31	V	32	Admin - Interest Expense		Provena Health Services	100.00%	179,142	179,142	31
32	V	39	Ancillary Services - Other	779,938	Provena Senior Services Pharmacy	100.00%	779,938		32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 1,000,516			$ 1,708,525	$ * 708,009	39

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

Facility Name & ID Number Provena McAuley Manor # 0042879 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		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 McAuley Manor # 0042879 Report Period Beginning: 1/1/2010 Ending: 2/31/2010

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 [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Provena Senior Services
Street Address: 19065 Hickory Creek Drive, Ste 310
City / State / Zip Code: Mokena, IL 60448
Phone Number: (708)478-7900
Fax Number: (708)478-5387

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	Food	Management Fee Income	6,595,714	19	$ 28,071	$	492,408	$ 2,096	1
2	5	Utilities	Management Fee Income	6,595,714	19	68,922		492,408	5,145	2
3	6	Maintenance - Other	Management Fee Income	6,595,714	19	12,909		492,408	964	3
4	11	Activities-Special Events	Management Fee Income	6,595,714	19	2,299		492,408	172	4
5	17	Admin - Misc. Other	Management Fee Income	6,595,714	19	50,355		492,408	3,759	5
6	17	Administrative Salaries	Management Fee Income	6,595,714	19	2,627,432	2,627,432	492,408	196,153	6
7	19	Professional Services	Management Fee Income	6,595,714	19	147,379		492,408	11,003	7
8	20	Dues,Subscriptions	Management Fee Income	6,595,714	19	55,559		492,408	4,148	8
9	21	Clerical Supplies	Management Fee Income	6,595,714	19	68,996		492,408	5,151	9
10	22	Employee Benefits	Management Fee Income	6,595,714	19	650,662		492,408	48,576	10
11	23	Education/Conference	Management Fee Income	6,595,714	19	4,261		492,408	318	11
12	24	Travel	Management Fee Income	6,595,714	19	39,252		492,408	2,930	12
13	26	Insurance	Management Fee Income	6,595,714	19	(5,591)		492,408	(417)	13
14	30	Depreciation	Management Fee Income	6,595,714	19	34,889		492,408	2,605	14
15	32	Interest	Management Fee Income	6,595,714	19	2,891,431		492,408	215,862	15
16	34	Rent - Facility	Management Fee Income	6,595,714	19	221,352		492,408	16,525	16
17	35	Rent - Equipment	Management Fee Income	6,595,714	19	28,311		492,408	2,114	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 6,926,489	$ 2,627,432		$ 517,104	25

Facility Name & ID Number Provena McAuley Manor # 0042879 Report Period Beginning: 1/1/2010 Ending: 2/31/2010

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 [X] 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Admin Salaries	Operating Expense	1,061,750	10	$ 903,952	$ 903,952	90,325	$ 76,901	1
2	22	Employee Benefits	Operating Expense	1,061,750	10	619,921		90,325	52,738	2
3	30	Depreciation	Operating Expense	1,061,750	10	737,143		90,325	62,710	3
4	34	Rent Facility	Operating Expense	1,061,750	10	234,632		90,325	19,961	4
5	19	Admin Consulting,Other	Operating Expense	1,061,750	10	940,516		90,325	80,011	5
6	17	Information Systems Salaries	Operating Expense	1,712,144	10	363,360	363,360	130,253	27,643	6
7	22	Information Systems Benefits	Operating Expense	1,712,144	10	338,352		130,253	25,740	7
8	17	Information Systems - Other	Operating Expense	1,712,144	10	157,216		130,253	11,960	8
9	17	Admin Salaries	Direct Cost	1,061,750	10	545,118	545,118	90,325	46,374	9
10	17	Information Systems Salaries	Direct Cost	1,712,144	10	427,541	427,541	130,253	32,526	10
11	6	Information Systems - Equip Mair	Direct Cost	1,712,144	10	358,615		130,253	27,282	11
12	19	Admin Consulting,Other	Direct Cost	1,061,750	10	570,021		90,325	48,493	12
13	32	Admin - Interest Expense	Direct Cost	1,061,750	10	2,105,774		90,325	179,142	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					$ 8,302,161	$ 2,239,971		$ 691,481	25

Facility Name & ID Number Provena McAuley Manor # 0042879 Report Period Beginning: 1/1/2010 Ending: 2/31/2010

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 [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Provena Senior Services Pharmacy
Street Address: 1475 Harvard Dr.
City / State / Zip Code: Kankakee, IL 60901
Phone Number: (815)928-6141
Fax Number: (815)946-3238

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	Ancillary Services - Other	Direct Allocation			$	$		$ 779,938	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					$	$		$ 779,938	25

Facility Name & ID Number Provena McAuley Manor # 0042879 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Home Office Allocation						$	$			$ 395,004	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 395,004	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$ 395,004	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 McAuley Manor **#** 0042879 **Report Period Beginning:** 1/1/2010 **Ending:** 12/31/2010

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	2005	8
	2006	9
	2007	10
	2008	11
	2009	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2009	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Provena McAuley Manor COUNTY Kane

FACILITY IDPH LICENSE NUMBER 0042879

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2009 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number Provena McAuley Manor # 0042879 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 51,000 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 2

C. Does the Operating Entity? [X] (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? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (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 [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number Provena McAuley Manor # 0042879 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	87		1986	1986	$ 4,218,962	$ 168,758	25	$ 168,758	$	$ 4,134,583	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10	Various			1987	9,470		15			9,450	10
11	Various			1988	35,230	592	19	592		33,849	11
12	Various			1989	7,670		15			7,670	12
13	Various			1990	2,400		15			2,400	13
14	Various			1991	11,296		14			11,168	14
15	Various			1992	1,500		10			1,500	15
16	Various			1993	7,744		10			7,744	16
17	Various			1994	18,925		8			18,925	17
18	Various			1995	22,015		8			22,015	18
19	Various			1996	63,956	4,152	15	4,152		58,778	19
20	Various			1997	7,144		5			7,144	20
21	Various			1999	2,941		5			2,941	21
22	Various			2000	31,736	1,527	19	1,527		17,232	22
23	Various			2001	62,210	3,309	9	3,309		60,555	23
24	Various			2002	57,057	4,902	9	4,572	(329)	51,721	24
25	Various			2003	65,471	5,464	12	5,464		41,013	25
26	Various			2004	92,928	9,076	10	9,076		61,103	26
27	Various			2005	233,353	17,387	14	17,387		100,169	27
28	Various			2006	69,254	5,415	13	5,415		22,913	28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Provena McAuley Manor # 0042879 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	DINING ROOM FLOORING	2007	$ 9,600	$ 960	10	$ 960	$	$ 3,360	37
38	STAINLESSWALL BACKING - FLOOR TO CE	2007	6,737	674	10	674		2,358	38
39	PLUMBINGWORK	2007	5,858	293	20	293		1,025	39
40	HVAC WORK(CHILLER)	2007	159,900	10,660	15	10,660		37,310	40
41	BLANKET WARMER	2007	10,199	1,020	10	1,020		3,570	41
42	CCTV, ACCESS CNTRL,AND NURSE CALL	2007	45,830	4,583	10	4,583		15,651	42
43	KITCHEN MUA UNIT	2007	86,736	5,782	15	5,782		20,238	43
44	FIRE ALARM SYSTEM	2007	74,690	7,469	10	7,469		26,142	44
45									45
46	DINING ROOM PROJECT	2008	12,187	1,219	10	1,219		2,477	46
47	BATH & SHOWER ROOMREMODEL	2008	17,549	1,755	10	1,755		4,387	47
48	ROOF REPAIR	2008	6,490	649	10	649		1,623	48
49									49
50	DRAIN REPAIRS	2009	6,683	955	7	955		1,432	50
51	FIRE DOOR	2009	14,215	948	15	948		1,421	51
52	ROOF REPLACEMENT	2009	90,154	9,015	10	9,015		13,465	52
53	CEILING AND PIPE REPAIRS INCONVENT	2009	13,125	1,313	10	1,313		1,969	53
54	DINING ROOM FLOORING AND WALL COVERI	2009	20,223	2,022	10	2,022		2,022	54
55	DEDUCTION OF NON-CARE ASSETS	2009	(13,125)	(1,313)	-10	(1,313)		(1,969)	55
56									56
57	REPLACEMENT OF WINDOW TREATMENTS	2010	4,279	428	5	856	428	428	57
58	PATIENT ROOM WALL COVERINGSAND PAIN	2010	22,899	1,145	10	2,290	1,145	1,145	58
59	HVAC REPAIRS	2010	20,877	1,491	7	2,982	1,491	1,491	59
60	REPLACE EXISTING WINDOW FRAMES & WIN	2010	36,723	918	20	1,836	918	918	60
61	PAINTINGOF HALLWAYS AND CONVENT	2010	10,064	1,006	5	2,013	1,006	1,006	61
62	REPLACEMENT OF CARPETING INCOMMUNIT	2010	8,849	885	5	1,770	885	885	62
63	INSTALL NEW ELECTRONIC DOOREDGE	2010	5,060	253	10	506	253	253	63
64	DX-9100 BASE AND TEMPERATURE CONTROL	2010	3,991	200	10	399	200	200	64
65	LEAK REPAIRS \ DUCTWORK INSULATION A	2010	9,757	325	15	650	325	325	65
66	DEDUCTION OF NON-CARE ASSETS	2010	(10,064)	(1,006)	-5	(2,013)	(1,006)	(1,006)	66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 5,700,745	$ 274,229		$ 279,544	$ 5,315	$ 4,814,999	70

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

Facility Name & ID Number Provena McAuley Manor # 0042879 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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	$ 578,632	$ 57,635	$ 57,635	$	11	$ 235,426	71
72	Current Year Purchases	136,471	8,451	16,902	8,451	9	8,451	72
73	Fully Depreciated Assets	162,804				7	162,804	73
74	Home Office Allocation		65,315	65,315				74
75	TOTALS	$ 877,907	$ 131,401	$ 139,852	$ 8,451		$ 406,680	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	1999 FORDELDORADO-15 CAP	1999	$ 42,261	$	$	$	8	$ 42,261	76
77										77
78										78
79										79
80	TOTALS			$ 42,261	$	$	$		$ 42,261	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)	$ 6,620,913	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 405,630	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 419,396	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 13,766	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 5,263,940	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Provena McAuley Manor # 0042879 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Home Office Allocation				16,525			5
6								6
7	TOTAL				$ 16,525 **			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 ☒ X NO Terms: *

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.	/2011	$
13.	/2012	$
14.	/2013	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO
16. Rental Amount for movable equipment: $ 42,009 Description: Nursing $30,667; Plant Eng $144; Admin $9,084; Home Office $2114
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

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

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

Facility Name & ID Number Provena McAuley Manor # 0042879 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		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.

STATE OF ILLINOIS

Facility Name & ID Number Provena McAuley Manor # 0042879 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a,3	hrs	$	5,132	$ 366,975	$	5,132	$ 366,975	1
2	Licensed Speech and Language Development Therapist	10a,3	hrs		610	43,638		610	43,638	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a,3	hrs		6,166	455,211		6,166	455,211	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				779,938		779,938	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			$	11,908	$ 865,824	$ 779,938	11,908	$ 1,645,762	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.

STATE OF ILLINOIS

Facility Name & ID Number Provena McAuley Manor # 0042879 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2010 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 12,905,317	$	1
2	Cash-Patient Deposits	106,041		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	11,828,283		3
4	Supply Inventory (priced at)	704,078		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	214,949		7
8	Accounts Receivable (owners or related parties)	49,434		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 25,808,102	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	8,146,223		12
13	Land	6,880,789		13
14	Buildings, at Historical Cost	88,483,063		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	20,359,968		16
17	Accumulated Depreciation (book methods)	(60,063,987)		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):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 63,806,056	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 89,614,158	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 5,914,297	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,171,680		28
29	Short-Term Notes Payable	56,068		29
30	Accrued Salaries Payable	3,651,233		30
31	Accrued Taxes Payable (excluding real estate taxes)	120,716		31
32	Accrued Real Estate Taxes(Sch.IX-B)	1,242,086		32
33	Accrued Interest Payable	12,331		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to Related Party	1,099,900		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 13,268,311	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,108,871		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	442,616		42
	Other Long-Term Liabilities(specify):			
43	Conditional Asset Retirement	438,744		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,990,231	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 15,258,542	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 74,355,616	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 89,614,158	$	48

*(See instructions.)

Facility Name & ID Number Provena McAuley Manor **#** 0042879 **Report Period Beginning:** 1/1/2010 **Ending:** 12/31/2010

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 73,769,457	1
2	Restatements (describe):		2
3	**Transfer to Affiliates**	(2,072,160)	3
4	**Adj. To reconcile consolidated equity & consolidated income**	1,906,095	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 73,603,392	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	640,532	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	232,870	11
12	Expenditures for Specific Purposes	(121,178)	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)**	$ 752,224	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)**	$ 74,355,616	24 *

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

Facility Name & ID Number Provena McAuley Manor # 0042879 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,681,857	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,681,857	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,719,028	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,719,028	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	19,297	13
14	Non-Patient Meals	9,145	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	752,188	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	21,289	20
21	Other Medical Services		21
22	Laundry	15,044	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 816,963	23
	D. Non-Operating Revenue		
24	Contributions	54,743	24
25	Interest and Other Investment Income***	6,674	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 61,417	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Purchase Rebates	258,196	28
28a	Misc Income & Gain/Loss SOFA	163,612	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 421,808	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,701,073	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,061,239	31
32	Health Care	3,686,496	32
33	General Administration	2,133,715	33
	B. Capital Expense		
34	Ownership	351,390	34
	C. Ancillary Expense		
35	Special Cost Centers	779,938	35
36	Provider Participation Fee	47,763	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,060,541	40
41	**Income before Income Taxes (line 30 minus line 40)****	640,532	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 640,532	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 McAuley Manor # 0042879 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,948	2,096	$ 101,296	$ 48.33	1
2	Assistant Director of Nursing	1,773	2,053	78,745	38.36	2
3	Registered Nurses	31,364	33,481	1,009,716	30.16	3
4	Licensed Practical Nurses	5,396	5,641	154,934	27.47	4
5	CNAs & Orderlies	60,526	65,087	942,141	14.48	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,212	4,548	78,006	17.15	8
9	Activity Director	1,960	2,080	20,047	9.64	9
10	Activity Assistants	4,610	4,842	42,866	8.85	10
11	Social Service Workers	2,918	3,095	49,085	15.86	11
12	Dietician	1,253	1,373	16,637	12.12	12
13	Food Service Supervisor	2,020	2,080	22,997	11.06	13
14	Head Cook	6,278	6,624	57,367	8.66	14
15	Cook Helpers/Assistants	14,182	15,048	115,108	7.65	15
16	Dishwashers					16
17	Maintenance Workers	4,984	5,452	86,252	15.82	17
18	Housekeepers	11,743	13,021	138,871	10.67	18
19	Laundry	2,042	2,267	25,995	11.47	19
20	Administrator	1,812	2,080	104,217	50.10	20
21	Assistant Administrator	1,672	1,808	54,364	30.07	21
22	Other Administrative	3,304	3,773	46,442	12.31	22
23	Office Manager					23
24	Clerical	4,058	4,378	36,813	8.41	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 C: Admissions	4,836	5,222	97,691	18.71	32
33	Other(specify) Pastoral	1,788	1,984	35,965	18.13	33
34	TOTAL (lines 1 - 33)	174,679	188,033	$ 3,315,555 *	$ 17.63	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	75	$ 6,806	1,3	35
36	Medical Director	80	12,000	9,3	36
37	Medical Records Consultant	16	1,110	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	12	551	11,3	44
45	Social Service Consultant	35	1,911	12,3	45
46	Other(specify)				46
47					47
48	Rehab Medical Director	120	18,000	9,3	48
49	TOTAL (lines 35 - 48)	338	$ 40,378		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	65	$ 4,039	10,3	50
51	Licensed Practical Nurses	8	336	10,3	51
52	Certified Nurse Assistants/Aides	23	584	10,3	52
53	TOTAL (lines 50 - 52)	96	$ 4,959		53

Facility Name & ID Number Provena McAuley Manor # 0042879 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jennifer Roach	Administrator	0	$ 104,217
Administrative Staff	Asst Administrator	0	54,364
Administrative Staff	Human Resources	0	12,778
Administrative Staff	Admissions	0	97,691
Administrative Staff	Receptionist	0	36,813
Administrative Staff	Bookkeeper	0	33,664
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 339,527

B. Administrative - Other

Description	Amount
Corporate Service Fee	$ 90,325
Corporate IS Fee	130,253
Mgmt Fee	299,604
Mgmt Fee Interest	192,804
TOTAL (agree to Schedule V, line 17, col. 3)	$ 712,986
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Legal Expense	Various	$ 5,000
Shredding	Various	875
Survey & Analytical Tools	Various	2,707
Outsourced Services	Various	1,086
Audit Expense	Various	4,000
Collection Fee	Various	40
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 13,708

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 92,100
Unemployment Compensation Insurance	31,033
FICA Taxes	233,273
Employee Health Insurance	248,885
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Life Insurance	14,626
Pension	113,269
Employee Recognition	772
Executive Benefits	6,805
Employment Screenings	27,439
Home Office Allocation	202,613
TOTAL (agree to Schedule V, line 22, col.8)	$ 970,815

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 49)	
Patient Background Checks 449	
Employee Recruitment	
Dues & Subscriptions	12,820
Advertising & Public Relations	31,796
Home Office Allocation	4,148
Less: Public Relations Expense	( )
Non-allowable advertising	(29,590)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 19,174

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	1,914
Seminar Expense	
Home Office Allocation	2,930
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,844

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Provena McAuley Manor # 0042879 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Provena McAuley Manor # 0042879 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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 $4,112**

(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? **No** If YES, what is the capacity? **N/A**

(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. $ **36,012** 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. $ **47,763**
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. $ **9,145**

(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.