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: 0041871

Facility Name: Provena St. Joseph Center

Address: 659 E. Jefferson (Number) Freeport (City) 61032 (Zip Code)

County: Stephenson

Telephone Number: (815) 232-6181 **Fax #** (815) 232-6143

HFS ID Number:

Date of Initial License for Current Owners: 07/01/96

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 St. Joseph Center # 0041871 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 _____

	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	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 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	25,005	7,705	6,133	38,843	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	25,005	7,705	6,133	38,843	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.68%

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 7/1/1996

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 120 and days of care provided 5,007

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: 12/31/2010 Fiscal Year: 12/31/10

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

Facility Name & ID Number Provena St. Joseph Center # 0041871 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	438,359	36,996	19,242	494,597		494,597		494,597			1
2	Food Purchase		216,169		216,169		216,169	(56,956)	159,213			2
3	Housekeeping	126,127	28,009		154,136		154,136		154,136			3
4	Laundry		2,068	113,932	116,000		116,000		116,000			4
5	Heat and Other Utilities			173,466	173,466		173,466	5,298	178,764			5
6	Maintenance	140,072	25,637	67,657	233,366		233,366	51,154	284,520			6
7	Other (specify):* **Pastoral**	52,172	466	23,706	76,344		76,344	(23,609)	52,735			7
8	**TOTAL General Services**	756,730	309,345	398,003	1,464,078		1,464,078	(24,113)	1,439,965			8
	B. Health Care and Programs											
9	Medical Director			11,000	11,000		11,000		11,000			9
10	Nursing and Medical Records	2,251,748	146,290	12,797	2,410,835		2,410,835		2,410,835			10
10a	Therapy			446,625	446,625		446,625		446,625			10a
11	Activities	88,092	739	2,767	91,598		91,598	177	91,775			11
12	Social Services	24,357		328	24,685		24,685		24,685			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,364,197	147,029	473,517	2,984,743		2,984,743	177	2,984,920			16
	C. General Administration											
17	Administrative	299,911	17,341	735,281	1,052,533		1,052,533	(200,991)	851,542			17
18	Directors Fees											18
19	Professional Services			13,114	13,114		13,114	(61,458)	(48,344)			19
20	Dues, Fees, Subscriptions & Promotions			34,822	34,822		34,822	(13,609)	21,213			20
21	Clerical & General Office Expenses			45,188	45,188		45,188	5,304	50,492			21
22	Employee Benefits & Payroll Taxes			1,019,354	1,019,354		1,019,354	209,402	1,228,756			22
23	Inservice Training & Education			3,341	3,341		3,341	328	3,669			23
24	Travel and Seminar			1,873	1,873		1,873	3,017	4,890			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			140,928	140,928		140,928	(430)	140,498			26
27	Other (specify):* **Bad Debt**			31,706	31,706		31,706	(31,706)				27
28	**TOTAL General Administration**	299,911	17,341	2,025,607	2,342,859		2,342,859	(90,143)	2,252,716			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,420,838	473,715	2,897,127	6,791,680		6,791,680	(114,079)	6,677,601			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Provena St. Joseph Center #0041871 Report Period Beginning: 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	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			276,047	276,047		276,047	85,860	361,907			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							402,043	402,043			32
33	Real Estate Taxes			110,916	110,916		110,916		110,916			33
34	Rent-Facility & Grounds							17,015	17,015			34
35	Rent-Equipment & Vehicles			9,737	9,737		9,737	2,176	11,913			35
36	Other (specify):*											36
37	**TOTAL Ownership**			396,700	396,700		396,700	507,094	903,794			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			391,960	391,960		391,960	(255,423)	136,537			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			65,880	65,880		65,880		65,880			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			457,840	457,840		457,840	(255,423)	202,417			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,420,838	473,715	3,751,667	7,646,220		7,646,220	137,592	7,783,812			45

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

Facility Name & ID Number Provena St. Joseph Center # 0041871 Report Period Beginning: 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	(59,114)	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	18,309	30		9
10	Interest and Other Investment Income	(5,526)	32		10
11	Discounts, Allowances, Rebates & Refunds	(255,423)	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	(31,706)	27		24
25	Fund Raising, Advertising and Promotional	(17,880)	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)**	$ (351,340)		$	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)	512,541		34
35	Other- Attach Schedule	(23,609)		35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 488,932		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 137,592		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

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Provena St. Joseph Center

ID# **0041871**

Report Period Beginning: **1/1/2010**

Ending: **12/31/2010**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Development Misc	$ (23,609)	7	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(23,609)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Provena St. Joseph Center # 0041871 **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 TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(59,114)	2,158	0	0	0	0	0	0	0	0	0	(56,956)	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	5,298	0	0	0	0	0	0	0	0	0	5,298	5
6	Maintenance	0	992	50,162	0	0	0	0	0	0	0	0	51,154	6
7	Other (specify):*	(23,609)	0	0	0	0	0	0	0	0	0	0	(23,609)	7
8	**TOTAL General Services**	(82,723)	8,448	50,162	0	0	0	0	0	0	0	0	(24,113)	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	177	0	0	0	0	0	0	0	0	0	177	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	177	0	0	0	0	0	0	0	0	0	177	16
	C. General Administration													
17	Administrative	0	(301,163)	100,172	0	0	0	0	0	0	0	0	(200,991)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	11,329	(72,787)	0	0	0	0	0	0	0	0	(61,458)	19
20	Fees, Subscriptions & Promotions	(17,880)	4,271	0	0	0	0	0	0	0	0	0	(13,609)	20
21	Clerical & General Office Expenses	0	5,304	0	0	0	0	0	0	0	0	0	5,304	21
22	Employee Benefits & Payroll Taxes	0	50,015	159,387	0	0	0	0	0	0	0	0	209,402	22
23	Inservice Training & Education	0	328	0	0	0	0	0	0	0	0	0	328	23
24	Travel and Seminar	0	3,017	0	0	0	0	0	0	0	0	0	3,017	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	(430)	0	0	0	0	0	0	0	0	0	(430)	26
27	Other (specify):*	(31,706)	0	0	0	0	0	0	0	0	0	0	(31,706)	27
28	**TOTAL General Administration**	(49,586)	(227,329)	186,772	0	0	0	0	0	0	0	0	(90,143)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(132,309)	(218,704)	236,934	0	0	0	0	0	0	0	0	(114,079)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Provena St. Joseph Center # 0041871 **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	18,309	0	67,551	0	0	0	0	0	0	0	0	85,860	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(5,526)	0	407,569	0	0	0	0	0	0	0	0	402,043	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	17,015	0	0	0	0	0	0	0	0	17,015	34
35	Rent-Equipment & Vehicles	0	0	2,176	0	0	0	0	0	0	0	0	2,176	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	12,783	0	494,311	0	0	0	0	0	0	0	0	507,094	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	(255,423)	0	0	0	0	0	0	0	0	0	0	(255,423)	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**	(255,423)	0	0	0	0	0	0	0	0	0	0	(255,423)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(374,949)	(218,704)	731,245	0	0	0	0	0	0	0	0	137,592	45

Facility Name & ID Number Provena St. Joseph Center # 0041871 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%	$ 2,158	$ 2,158	1
2	V	5	Utilities		Provena Senior Services	100.00%	5,298	5,298	2
3	V	6	Maintenance - Other		Provena Senior Services	100.00%	992	992	3
4	V	11	Activities-Special Events		Provena Senior Services	100.00%	177	177	4
5	V	17	Admin - Misc. Other		Provena Senior Services	100.00%	3,871	3,871	5
6	V	17	Administrative Salaries	507,000	Provena Senior Services	100.00%	201,966	(305,034)	6
7	V	19	Professional Services		Provena Senior Services	100.00%	11,329	11,329	7
8	V	20	Dues,Subscriptions		Provena Senior Services	100.00%	4,271	4,271	8
9	V	21	Clerical Supplies		Provena Senior Services	100.00%	5,304	5,304	9
10	V	22	Employee Benefits		Provena Senior Services	100.00%	50,015	50,015	10
11	V	23	Education/Conference		Provena Senior Services	100.00%	328	328	11
12	V	24	Travel		Provena Senior Services	100.00%	3,017	3,017	12
13	V	26	Insurance		Provena Senior Services	100.00%	(430)	(430)	13
14	Total			$ 507,000			$ 288,296	$ * (218,704)	14

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

Facility Name & ID Number Provena St. Joseph Center # 0041871 Report Period Beginning: 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%	$ 2,682	$ 2,682	15
16	V	32	Interest		Provena Senior Services	100.00%	222,259	222,259	16
17	V	34	Rent - Facility		Provena Senior Services	100.00%	17,015	17,015	17
18	V	35	Rent - Equipment		Provena Senior Services	100.00%	2,176	2,176	18
19	V	17	Admin Salaries		Provena Health Services	100.00%	79,549	79,549	19
20	V	22	Employee Benefits		Provena Health Services	100.00%	54,554	54,554	20
21	V	30	Depreciation		Provena Health Services	100.00%	64,869	64,869	21
22	V	19	Admin Consulting,Other	93,435	Provena Health Services	100.00%	20,648	(72,787)	22
23	V	17	Information Systems Salaries		Provena Health Services	100.00%	82,766	82,766	23
24	V	22	Information Systems Benefits		Provena Health Services	100.00%	28,618	28,618	24
25	V	17	Information Systems - Other	134,846	Provena Health Services	100.00%	26,648	(108,198)	25
26	V	17	Admin Salaries		Provena Health Services	100.00%	12,382	12,382	26
27	V	22	Employee Benefits		Provena Health Services	100.00%	47,971	47,971	27
28	V	17	Information Systems Salaries		Provena Health Services	100.00%	33,673	33,673	28
29	V	22	Information Systems Benefits		Provena Health Services	100.00%	28,244	28,244	29
30	V	6	Information Systems - Equip Maint		Provena Health Services	100.00%	50,162	50,162	30
31	V	32	Admin - Interest Expense		Provena Health Services	100.00%	185,310	185,310	31
32	V	39	Ancillary Services - Other	391,960	Provena Senior Services Pharmacy	100.00%	391,960		32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 620,241			$ 1,351,486	$ * 731,245	39

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

Facility Name & ID Number Provena St. Joseph Center # 0041871 Report Period Beginning: 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 St. Joseph Center # 0041871 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	$	507,000	$ 2,158	1
2	5	Utilities	Management Fee Income	6,595,714	19	68,922		507,000	5,298	2
3	6	Maintenance - Other	Management Fee Income	6,595,714	19	12,909		507,000	992	3
4	11	Activities-Special Events	Management Fee Income	6,595,714	19	2,299		507,000	177	4
5	17	Admin - Misc. Other	Management Fee Income	6,595,714	19	50,355		507,000	3,871	5
6	17	Administrative Salaries	Management Fee Income	6,595,714	19	2,627,432	2,627,432	507,000	201,966	6
7	19	Professional Services	Management Fee Income	6,595,714	19	147,379		507,000	11,329	7
8	20	Dues,Subscriptions	Management Fee Income	6,595,714	19	55,559		507,000	4,271	8
9	21	Clerical Supplies	Management Fee Income	6,595,714	19	68,996		507,000	5,304	9
10	22	Employee Benefits	Management Fee Income	6,595,714	19	650,662		507,000	50,015	10
11	23	Education/Conference	Management Fee Income	6,595,714	19	4,261		507,000	328	11
12	24	Travel	Management Fee Income	6,595,714	19	39,252		507,000	3,017	12
13	26	Insurance	Management Fee Income	6,595,714	19	(5,591)		507,000	(430)	13
14	30	Depreciation	Management Fee Income	6,595,714	19	34,889		507,000	2,682	14
15	32	Interest	Management Fee Income	6,595,714	19	2,891,431		507,000	222,259	15
16	34	Rent - Facility	Management Fee Income	6,595,714	19	221,352		507,000	17,015	16
17	35	Rent - Equipment	Management Fee Income	6,595,714	19	28,311		507,000	2,176	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 6,926,489	$ 2,627,432		$ 532,428	25

Facility Name & ID Number Provena St. Joseph Center # 0041871 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	93,435	$ 79,549	1
2	22	Employee Benefits	Operating Expense	1,061,750	10	619,921		93,435	54,554	2
3	30	Depreciation	Operating Expense	1,061,750	10	737,143		93,435	64,869	3
4	34	Rent Facility	Operating Expense	1,061,750	10	234,632		93,435	20,648	4
5	19	Admin Consulting,Other	Operating Expense	1,061,750	10	940,516		93,435	82,766	5
6	17	Information Systems Salaries	Operating Expense	1,712,144	10	363,360	363,360	134,846	28,618	6
7	22	Information Systems Benefits	Operating Expense	1,712,144	10	338,352		134,846	26,648	7
8	17	Information Systems - Other	Operating Expense	1,712,144	10	157,216		134,846	12,382	8
9	17	Admin Salaries	Direct Cost	1,061,750	10	545,118	545,118	93,435	47,971	9
10	17	Information Systems Salaries	Direct Cost	1,712,144	10	427,541	427,541	134,846	33,673	10
11	6	Information Systems - Equip Mair	Direct Cost	1,712,144	10	358,615		134,846	28,244	11
12	19	Admin Consulting,Other	Direct Cost	1,061,750	10	570,021		93,435	50,162	12
13	32	Admin - Interest Expense	Direct Cost	1,061,750	10	2,105,774		93,435	185,310	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		$ 715,394	25

Facility Name & ID Number Provena St. Joseph Center # 0041871 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 Pharmacy
Street Address: 1475 Harvard Drive
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			$	$		$ 391,960	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					$	$		$ 391,960	25

Facility Name & ID Number Provena St. Joseph Center # 0041871 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						$	$			$ 407,569	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 407,569	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$ 407,569	15

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

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

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

Facility Name & ID Number Provena St. Joseph Center **#** 0041871 **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.)		$ 110,916	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.		$ 110,916	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 St. Joseph Center COUNTY Stephenson

FACILITY IDPH LICENSE NUMBER 0041871

CONTACT PERSON REGARDING THIS REPORT Lynda Olinski

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

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

Enter the tax index number and real estate tax assessed for 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.	To be determined		$ 110,916.00	$ 110,916.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 110,916.00	$ 110,916.00

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 St. Joseph Center # 0041871 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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? [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	Nursing Home		1996	$ 1,400,000	1
2					2
3	TOTALS			$ 1,400,000	3

Facility Name & ID Number Provena St. Joseph Center # 0041871 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	120		1996	1996	$ 2,500,000	$ 62,500	40	$ 62,500	$	$ 906,250	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various										9
10	Various			1997	21,577	1,135	14	1,135		23,015	10
11	Various			1998	3,718		10			3,718	11
12	Various			1999	78,698	2,227	16	2,227		59,770	12
13	Various			2000			5			9,480	13
14	Various			2001	19,599	827	10	827		22,548	14
15	Various			2002	46,639	2,235	10	2,235		38,909	15
16	Various			2003	75,143	6,937	11	6,937		54,083	16
17	Various			2004	29,458	1,376	7	1,376		26,198	17
18	Various			2005	98,930	7,484	15	7,484		41,918	18
19	Various			2006	64,266	5,973	12	5,973		24,073	19
20											20
21	CULTURE CHANGE			2007	13,650	1,365	10	1,365		4,412	21
22	PAINTINGOF NURSINGHOME			2007	6,264	1,253	5	1,253		4,385	22
23	DINING ROOM PAINTING			2007	9,075	1,815	5	1,815		6,353	23
24	REWIRINGOF ELECTRICAL FORHOBAN HAL			2007	15,690	785	20	785		2,746	24
25	PT/OT REMODELING			2007	33,243	2,216	15	2,216		6,828	25
26	ENTRANCECANOPY			2007	665	67	10	67		233	26
27	LOBBY REMODEL			2007	24,214	1,614	15	1,614		5,650	27
28	ACCUTECHWANDERINGAND VOICE ANNOUNC			2007	27,827	2,783	10	2,783		9,739	28
29	WIRING FOR FIRE ALARMS / TIE INTO NE			2007	46,500	2,325	20	2,325		6,975	29
30	ENTRANCECANOPY / DRIVE			2007	3,568	357	10	357		1,070	30
31	DEDUCTION FOR NON-CARE ASSETS			2007	(15,690)	(785)	-20	(785)		(2,746)	31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Provena St. Joseph Center # 0041871 Report Period Beginning: 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	REMODEL OF CHURCH	2008	$ 42,100	$ 2,105	20	$ 2,105	$	$ 5,263	37
38	ELECTRICAL WORK FORMINISTRY	2008	8,100	405	20	405		1,013	38
39	NEW BASEBOARD COVERS FOR 64RESIDENT	2008	21,020	2,102	10	2,102		5,255	39
40	DINING ROOM RENOVATION	2008	9,030	753	12	753		1,881	40
41	WINDOWS FOR CLF 1STFLOOR	2008	3,424	342	10	342		856	41
42	MOBILE CABINET	2008	2,135	213	10	213		534	42
43	FLAG POLE	2008	3,785	189	20	189		473	43
44	PARKING LOT REPAIRS, CONCRETE WALKWA	2008	74,818	9,352	8	9,352		23,381	44
45	CANOPY PROJECT	2008	4,868	325	15	325		811	45
46	DEDUCTION FOR NON-CARE ASSETS	2008	(3,424)	(342)	-10	(342)		(856)	46
47									47
48	SPRINKLERREPAIRS	2009	4,185	209	20	209		314	48
49	COMPRESSOR REPAIRS	2009	5,365	447	12	447		671	49
50	HOT WATEREXCHANGER, EXPANSION TANK,	2009	55,826	5,583	10	5,583		8,374	50
51	ASPHALT PARKING LOT	2009	5,396	675	8	675		1,012	51
52	CARRIER 10 TON CONDENSING UNIT W/ LO	2009	6,590	439	15	439		659	52
53	GENERATORLOAD	2009	2,649	530	5	530		795	53
54	THIRD FLOOR MEN'S BATHROOMRENOVATIO	2009	17,605	1,760	10	1,760		2,641	54
55	15 SECONDDOOR MAGNETS, TRANSMITTERS	2009	15,440	1,544	10	1,544		2,316	55
56	CANOPY PROJECT	2009	57,918	3,861	15	3,861		5,001	56
57	DEDUCTION FOR NON-CARE ASSETS	2009	(17,605)	(1,760)	-10	(1,760)		(2,641)	57
58									58
59									59
60	CLF HOBANHALL HOTWATER HEATERS AND	2010	2,750	138	10	275	138	138	60
61	PAINTINGOF HALLWAYS IN NURSING HOME	2010	3,001	300	5	600	300	300	61
62	HVAC AIRDAMPER CONTROL MOTORS	2010	7,660	766	5	1,532	766	766	62
63	PHASE 3 FOR BOILER	2010	5,100	128	20	255	128	128	63
64	HUMIDIFIER SYSTEM -HONEYWELL STEAM	2010	5,960	373	8	745	373	373	64
65	CULTURE CHANGE	2010	27,077	903	15	1,805	903	903	65
66	PARKING LOT UPGRADES	2010	59,821	3,739	8	7,478	3,739	3,739	66
67	DEDUCTION FOR NON-CARE ASSETS	2010	(2,750)	(138)	-10	(275)	(138)	(138)	67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,530,876	$ 139,426		$ 145,633	$ 6,207	$ 1,319,563	70

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

Facility Name & ID Number Provena St. Joseph Center # 0041871 Report Period Beginning: 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	$ 1,059,169	$ 111,701	$ 111,701	$	11	$ 490,469	71
72	Current Year Purchases	202,580	11,964	23,928	11,964	9	11,964	72
73	Fully Depreciated Assets	456,340				9	456,340	73
74	Home Office Allocation		67,551	67,551				74
75	TOTALS	$ 1,718,090	$ 191,216	$ 203,179	$ 11,964		$ 958,773	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	2006 CHEVY UPLANDER(MAR	2007	$ 15,649	$ 3,912	$ 3,912	$	4	$ 13,693	76
77	Plant Engineering	2001 MERCURY SABLE/2003 F(	2001	57,398				3	57,398	77
78	Plant Engineering	1997 DODGE 2500 (3/4 TON) PI(	1997	24,090				5	24,090	78
79	Plant Engineering	2010 FORDSUPREME 12+2 CAI	2010	48,155	6,019	6,019		4	6,019	79
80	TOTALS			$ 145,292	$ 9,932	$ 9,932	$		$ 101,200	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)	$ 6,794,257	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 340,573	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 358,744	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 18,171	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,379,537	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 St. Joseph Center # 0041871 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				17,015			5
6								6
7	TOTAL				$ 17,015 **			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: $ 21,572 Description: Nursing $9,658; Administration $9,738; Home Office $2176
(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 St. Joseph Center # 0041871 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.

Facility Name & ID Number Provena St. Joseph Center

STATE OF ILLINOIS
0041871 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	$	2,956	$ 211,360	$	2,956	$ 211,360	1
2	Licensed Speech and Language Development Therapist	10a,3	hrs		169	13,116		169	13,116	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a,3	hrs		3,009	222,149		3,009	222,149	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				391,960		391,960	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			$	6,134	$ 446,625	$ 391,960	6,134	$ 838,585	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 St. Joseph Center # 0041871 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 St. Joseph Center **#** 0041871 **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**	2,981,586	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 74,678,883	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(434,959)	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)**	$ (323,267)	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 St. Joseph Center # 0041871 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	$ 5,772,075	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,772,075	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	739,798	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 739,798	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	477	12
13	Barber and Beauty Care	2,057	13
14	Non-Patient Meals	59,114	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	327,294	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 388,942	23
	D. Non-Operating Revenue		
24	Contributions	43,509	24
25	Interest and Other Investment Income***	5,526	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 49,035	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Purchase Rebates	255,423	28
28a	Misc Income & Gain/Loss SOFA	5,988	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 261,411	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,211,261	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,464,078	31
32	Health Care	2,984,743	32
33	General Administration	2,342,859	33
	B. Capital Expense		
34	Ownership	396,700	34
	C. Ancillary Expense		
35	Special Cost Centers	391,960	35
36	Provider Participation Fee	65,880	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,646,220	40
41	**Income before Income Taxes (line 30 minus line 40)****	(434,959)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (434,959)	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: 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	1,660	2,080	$ 88,668	$ 42.63	1
2	Assistant Director of Nursing	1,836	2,140	70,485	32.94	2
3	Registered Nurses	14,549	15,529	398,704	25.67	3
4	Licensed Practical Nurses	25,196	27,355	558,021	20.40	4
5	CNAs & Orderlies	85,231	92,505	1,062,987	11.49	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,843	5,930	72,883	12.29	8
9	Activity Director	1,824	2,036	30,999	15.23	9
10	Activity Assistants	5,497	5,959	57,093	9.58	10
11	Social Service Workers	1,932	2,080	24,357	11.71	11
12	Dietician	280	280	5,136	18.34	12
13	Food Service Supervisor	1,892	2,080	41,311	19.86	13
14	Head Cook	6,236	6,795	77,208	11.36	14
15	Cook Helpers/Assistants	31,664	34,120	314,704	9.22	15
16	Dishwashers					16
17	Maintenance Workers	9,480	10,489	140,072	13.35	17
18	Housekeepers	13,411	14,355	126,127	8.79	18
19	Laundry					19
20	Administrator	1,472	2,080	87,392	42.02	20
21	Assistant Administrator	480	480	15,844	33.01	21
22	Other Administrative	3,556	4,160	68,337	16.43	22
23	Office Manager					23
24	Clerical	4,506	4,816	48,839	10.14	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	3,809	4,186	79,499	18.99	32
33	Other(specify) Pastoral	1,880	2,080	52,172	25.08	33
34	TOTAL (lines 1 - 33)	221,234	241,535	$ 3,420,838 *	$ 14.16	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	185	$ 14,040	1,3	35
36	Medical Director	88	11,000	9,3	36
37	Medical Records Consultant	25	1,711	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	7	450	11,3	44
45	Social Service Consultant	7	450	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	312	$ 27,651		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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

Facility Name & ID Number Provena St. Joseph Center # 0041871 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Michelle Lindeman	Administrator	0	$ 87,392
Adminstrative Staff	Asst. Administrator	0	15,844
Adminstrative Staff	Bookkeeper	0	25,638
Adminstrative Staff	Admissions	0	79,499
Adminstrative Staff	Receptionist	0	48,839
Adminstrative Staff	Human Resources	0	42,699
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 299,911

B. Administrative - Other

Description	Amount
Corp Service Fee	$ 93,435
Corp Service IS Fee	134,846
Mgmt Fee	309,804
Mgmt Fee Interest	197,196
TOTAL (agree to Schedule V, line 17, col. 3)	$ 735,281
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Survey & Analytical Tools	Various	$ 2,077
Outsourced Services	Various	3,896
Living Design	Various	1,055
Audit	Various	4,000
Legal	Various	1,528
Collection Fee	Various	558
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 13,114

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 95,304
Unemployment Compensation Insurance	31,546
FICA Taxes	246,526
Employee Health Insurance	479,545
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Life Insurance	13,716
Pension	126,127
Employee Recognition	1,744
Executive Benefits	7,707
Employee Screenings	17,139
Home Office Allocation	209,402
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,228,756

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

Description	Line #	Amount
N/A		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 46)	
Patient Background Checks 102	
Employee Recruitment	2,545
Dues & Subscriptions	14,510
Advertising & Public Relations	17,767
Home Office Allocation	4,271
Less: Public Relations Expense	( )
Non-allowable advertising	(17,880)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 21,213

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	1,873
Seminar Expense	
Home Office Allocation	3,017
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,890

**See instructions.

Facility Name & ID Number Provena St. Joseph Center # 0041871 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 St. Joseph Center # 0041871 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 $6,179**

(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. $ **41,151** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **65,880**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **59,114**

(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.