FOR BHF USE

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2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

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: 0041046

Facility Name: Provena Cor Mariae Center

Address: 3330 Maria Linden Dr (Number) Rockford (City) 61114 (Zip Code)

County: Winnebago

Telephone Number: (815) 877-7416 **Fax #** (815) 877-4299

HFS ID Number:

Date of Initial License for Current Owners: 06/01/95

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 01/01/2011 to 12/31/2011 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 Cor Mariae Center # 0041046 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	4,760	9,775	11,273	25,808	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC		23,309		23,309	12
13	DD 16 OR LESS					13
14	TOTALS	4,760	33,084	11,273	49,117	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.07%

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 6/5 /1995

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 73 and days of care provided 9,128

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: 12/31/11 Fiscal Year: 12/31/11

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

Facility Name & ID Number Provena Cor Mariae Center # 0041046 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	514,966	86,603	28,804	630,373		630,373		630,373			1
2	Food Purchase		383,496		383,496		383,496	1,875	385,371			2
3	Housekeeping	167,460	40,013		207,473		207,473		207,473			3
4	Laundry	27,162	5,390	88,703	121,255		121,255		121,255			4
5	Heat and Other Utilities			294,370	294,370		294,370	6,400	300,770			5
6	Maintenance	126,540	52,993	112,335	291,868		291,868	78,026	369,894			6
7	Other (specify):* Pastoral Care	45,736	3,068	18,374	67,178		67,178	(4,881)	62,297			7
8	TOTAL General Services	881,864	571,563	542,586	1,996,013		1,996,013	81,420	2,077,433			8
	B. Health Care and Programs											
9	Medical Director			21,000	21,000		21,000		21,000			9
10	Nursing and Medical Records	2,546,654	249,186	55,662	2,851,502		2,851,502		2,851,502			10
10a	Therapy			1,071,459	1,071,459		1,071,459		1,071,459			10a
11	Activities	267,233	13,852	11,643	292,728		292,728	1,730	294,458			11
12	Social Services	87,481	573	427	88,481		88,481		88,481			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,901,368	263,611	1,160,191	4,325,170		4,325,170	1,730	4,326,900			16
	C. General Administration											
17	Administrative	467,375	50,291	955,361	1,473,027		1,473,027	(405,042)	1,067,985			17
18	Directors Fees											18
19	Professional Services			8,630	8,630		8,630	54,671	63,301			19
20	Dues, Fees, Subscriptions & Promotions			22,623	22,623		22,623	(4,470)	18,153			20
21	Clerical & General Office Expenses			63,369	63,369		63,369	7,090	70,459			21
22	Employee Benefits & Payroll Taxes			1,088,564	1,088,564		1,088,564	218,218	1,306,782			22
23	Inservice Training & Education			4,012	4,012		4,012	3,984	7,996			23
24	Travel and Seminar			14,828	14,828		14,828	4,366	19,194			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			110,804	110,804		110,804	(518)	110,286			26
27	Other (specify):* Bad Debt			60,335	60,335		60,335	(60,335)				27
28	TOTAL General Administration	467,375	50,291	2,328,526	2,846,192		2,846,192	(182,036)	2,664,156			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,250,607	885,465	4,031,303	9,167,375		9,167,375	(98,886)	9,068,489			29

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

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

Facility Name & ID Number Provena Cor Mariae Center #0041046 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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			437,906	437,906		437,906	69,115	507,021			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							416,495	416,495			32
33	Real Estate Taxes			1,060	1,060		1,060		1,060			33
34	Rent-Facility & Grounds							20,036	20,036			34
35	Rent-Equipment & Vehicles			13,182	13,182		13,182	3,213	16,395			35
36	Other (specify):*											36
37	**TOTAL Ownership**			452,148	452,148		452,148	508,859	961,007			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			655,562	655,562		655,562	(261,530)	394,032			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			39,968	39,968		39,968		39,968			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			695,530	695,530		695,530	(261,530)	434,000			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,250,607	885,465	5,178,981	10,315,053		10,315,053	148,443	10,463,496			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 Cor Mariae Center # 0041046 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	(1,211)	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	16,346	30		9
10	Interest and Other Investment Income	(9,509)	32		10
11	Discounts, Allowances, Rebates & Refunds	(261,530)	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	(2,493)	30		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	(60,335)	27		24
25	Fund Raising, Advertising and Promotional	(11,923)	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)**	$ (330,655)		$	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)	483,979		34
35	Other- Attach Schedule	(4,881)		35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 479,098		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 148,443		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 Cor Mariae Center

ID# 0041046

Report Period Beginning: 01/01/2011

Ending: 12/31/2011

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Development Misc	$ (3,731)	7	1
2	Development Other Supplies	(1,150)	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**	(4,881)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Provena Cor Mariae Center # 0041046 **Report Period Beginning:** 01/01/2011 **Ending:** 12/31/2011

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,211)	3,086	0	0	0	0	0	0	0	0	0	1,875	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	6,400	0	0	0	0	0	0	0	0	0	6,400	5
6	Maintenance	0	1,575	76,451	0	0	0	0	0	0	0	0	78,026	6
7	Other (specify):*	(4,881)	0	0	0	0	0	0	0	0	0	0	(4,881)	7
8	**TOTAL General Services**	(6,092)	11,061	76,451	0	0	0	0	0	0	0	0	81,420	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	1,730	0	0	0	0	0	0	0	0	0	1,730	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	1,730	0	0	0	0	0	0	0	0	0	1,730	16
	C. General Administration													
17	Administrative	0	(343,395)	(61,647)	0	0	0	0	0	0	0	0	(405,042)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	33,137	21,534	0	0	0	0	0	0	0	0	54,671	19
20	Fees, Subscriptions & Promotions	(11,923)	7,453	0	0	0	0	0	0	0	0	0	(4,470)	20
21	Clerical & General Office Expenses	0	7,090	0	0	0	0	0	0	0	0	0	7,090	21
22	Employee Benefits & Payroll Taxes	0	71,688	146,530	0	0	0	0	0	0	0	0	218,218	22
23	Inservice Training & Education	0	3,984	0	0	0	0	0	0	0	0	0	3,984	23
24	Travel and Seminar	0	4,366	0	0	0	0	0	0	0	0	0	4,366	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	(518)	0	0	0	0	0	0	0	0	0	(518)	26
27	Other (specify):*	(60,335)	0	0	0	0	0	0	0	0	0	0	(60,335)	27
28	**TOTAL General Administration**	(72,258)	(216,195)	106,417	0	0	0	0	0	0	0	0	(182,036)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(78,350)	(203,404)	182,868	0	0	0	0	0	0	0	0	(98,886)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Provena Cor Mariae Center # 0041046 **Report Period Beginning:** 01/01/2011 **Ending:** 12/31/2011

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	13,853	0	55,262	0	0	0	0	0	0	0	0	69,115	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(9,509)	0	426,004	0	0	0	0	0	0	0	0	416,495	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	20,036	0	0	0	0	0	0	0	0	20,036	34
35	Rent-Equipment & Vehicles	0	0	3,213	0	0	0	0	0	0	0	0	3,213	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	4,344	0	504,515	0	0	0	0	0	0	0	0	508,859	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	(261,530)	0	0	0	0	0	0	0	0	0	0	(261,530)	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	(261,530)	0	0	0	0	0	0	0	0	0	0	(261,530)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(335,536)	(203,404)	687,383	0	0	0	0	0	0	0	0	148,443	45

Facility Name & ID Number Provena Cor Mariae Center # 0041046 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		Provena Our Lady of Victory	Bourbonnais			
		Provena Pine View Care Center	St. Charles			
		Provena Geneva Care Center	Geneva			
		Provena Cor Mariae Center	Rockford			
		Provena St. Joseph Center	Freeport			
		Provena McAuley Manor	Aurora			
		Provena St. Anne Center	Rockford			

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 Life Connections	100.00%	$ 3,086	$ 3,086	1
2	V	5	Utilities		Provena Life Connections	100.00%	6,400	6,400	2
3	V	6	Maintenance - Other		Provena Life Connections	100.00%	1,575	1,575	3
4	V	11	Activities-Special Events		Provena Life Connections	100.00%	1,730	1,730	4
5	V	17	Admin - Misc. Other	667,596	Provena Life Connections	100.00%	6,014	(661,582)	5
6	V	17	Administrative Salaries		Provena Life Connections	100.00%	318,187	318,187	6
7	V	19	Professional Services		Provena Life Connections	100.00%	33,137	33,137	7
8	V	20	Dues,Subscriptions		Provena Life Connections	100.00%	7,453	7,453	8
9	V	21	Clerical Supplies		Provena Life Connections	100.00%	7,090	7,090	9
10	V	22	Employee Benefits		Provena Life Connections	100.00%	71,688	71,688	10
11	V	23	Education/Conference		Provena Life Connections	100.00%	3,984	3,984	11
12	V	24	Travel		Provena Life Connections	100.00%	4,366	4,366	12
13	V	26	Insurance		Provena Life Connections	100.00%	(518)	(518)	13
14	Total			$ 667,596			$ 464,192	$ * (203,404)	14

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

Facility Name & ID Number Provena Cor Mariae Center # 0041046 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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 Life Connections	100.00%	$ 3,836	$ 3,836	15
16	V	32	Interest		Provena Life Connections	100.00%	263,055	263,055	16
17	V	34	Rent - Facility		Provena Life Connections	100.00%	20,036	20,036	17
18	V	35	Rent - Equipment		Provena Life Connections	100.00%	3,213	3,213	18
19	V	17	Admin Salaries	128,919	Provena Health Services	100.00%	98,120	(30,799)	19
20	V	22	Employee Benefits		Provena Health Services	100.00%	51,916	51,916	20
21	V	30	Depreciation		Provena Health Services	100.00%	51,426	51,426	21
22	V	19	Admin Consulting,Other		Provena Health Services	100.00%	21,534	21,534	22
23	V	17	Information Systems Salaries	158,846	Provena Health Services	100.00%	42,582	(116,264)	23
24	V	22	Information Systems Benefits		Provena Health Services	100.00%	31,309	31,309	24
25	V	17	Information Systems - Other		Provena Health Services	100.00%	28,828	28,828	25
26	V	17	Admin Salaries		Provena Health Services	100.00%	19,150	19,150	26
27	V	22	Employee Benefits		Provena Health Services	100.00%	25,686	25,686	27
28	V	17	Information Systems Salaries		Provena Health Services	100.00%	37,438	37,438	28
29	V	22	Information Systems Benefits		Provena Health Services	100.00%	37,619	37,619	29
30	V	6	Information Systems - Equip Maint		Provena Health Services	100.00%	76,451	76,451	30
31	V	32	Admin - Interest Expense		Provena Health Services	100.00%	162,949	162,949	31
32	V	39	Ancillary Services - Other	655,562	Provena Senior Services Pharmacy	100.00%	655,562		32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 943,327			$ 1,630,710	$ * 687,383	39

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

Facility Name & ID Number Provena Cor Mariae Center # 0041046 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

VII. RELATED PARTIES

A. (Continued) **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.**

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Provena Villa Franciscan	Joliet				1
2			Provena Heritage Village	Kankakee				2
3					Provena Clinics	Various	Physician's Clinics	3
4					Provena Fortin Villa	Bourbonnais	Childrens Center	4
5					Provena Fox Knoll	Aurora	Retirement Comm	5
6					Provena Health	Frankfort	Parent Company	6
7					Provena Home Care	Various	Home Health	7
8					Provena Home Equipment		Home Equipment	8
9					Provena Hospice	Various	Hospice	9
10					Provena Hospitals	Various	Hospital	10
11					Provena Laverna Te	Avilla, IN	Independent Livin	11
12					Provena Meadowvie	Kankakee	Supportive Living	12
13					Provena Senior Ser	Mokena	Management Con	13
14					Provena Senior Ser	Kankakee	Pharmacy	14
15					Provena St. Joseph	Freeport	Adult Day Care	15
16					Provena St. Mary's /	Kankakee	Adult Day Care	16
17					Provena St. Vincent	Freeport	Community Living	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

Facility Name & ID Number Provena Cor Mariae Center # 0041046 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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 Cor Mariae Center # 0041046 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

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 Life Connections
Street Address: 19065 Hickory Creek Drive, Ste 310
City / State / Zip Code: Mokena, IL 60448
Phone Number: (708-478-7900
Fax Number: (708-4785387

	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	6,979,492	19	$ 32,265	$	667,596	$ 3,086	1
2	5	Utilities	Management Fee Income	6,979,492	19	66,913		667,596	6,400	2
3	6	Maintenance - Other	Management Fee Income	6,979,492	19	16,465		667,596	1,575	3
4	11	Activities-Special Events	Management Fee Income	6,979,492	19	18,086		667,596	1,730	4
5	17	Admin - Misc. Other	Management Fee Income	6,979,492	19	62,879		667,596	6,014	5
6	17	Administrative Salaries	Management Fee Income	6,979,492	19	3,326,538	3,326,538	667,596	318,187	6
7	19	Professional Services	Management Fee Income	6,979,492	19	346,433		667,596	33,137	7
8	20	Dues,Subscriptions	Management Fee Income	6,979,492	19	77,921		667,596	7,453	8
9	21	Clerical Supplies	Management Fee Income	6,979,492	19	74,124		667,596	7,090	9
10	22	Employee Benefits	Management Fee Income	6,979,492	19	749,474		667,596	71,688	10
11	23	Education/Conference	Management Fee Income	6,979,492	19	41,653		667,596	3,984	11
12	24	Travel	Management Fee Income	6,979,492	19	45,642		667,596	4,366	12
13	26	Insurance	Management Fee Income	6,979,492	19	(5,417)		667,596	(518)	13
14	30	Depreciation	Management Fee Income	6,979,492	19	40,099		667,596	3,836	14
15	32	Interest	Management Fee Income	6,979,492	19	2,750,151		667,596	263,055	15
16	34	Rent - Facility	Management Fee Income	6,979,492	19	209,473		667,596	20,036	16
17	35	Rent - Equipment	Management Fee Income	6,979,492	19	33,596		667,596	3,213	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 7,886,295	$ 3,326,538		$ 754,332	25

Facility Name & ID Number Provena Cor Mariae Center # 0041046 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

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	1,315,329	10	$ 1,001,096	$ 1,001,096	128,919	$ 98,120	1
2	22	Employee Benefits	Operating Expense	1,315,329	10	529,691		128,919	51,916	2
3	30	Depreciation	Operating Expense	1,315,329	10	524,686		128,919	51,426	3
4	34	Rent Facility	Operating Expense	1,315,329	10	219,709		128,919	21,534	4
5	19	Admin Consulting,Other	Operating Expense	1,315,329	10	434,452		128,919	42,582	5
6	17	Information Systems Salaries	Operating Expense	1,621,586	10	319,617	319,617	158,846	31,309	6
7	22	Information Systems Benefits	Operating Expense	1,621,586	10	294,294		158,846	28,828	7
8	17	Information Systems - Other	Operating Expense	1,621,586	10	195,496		158,846	19,150	8
9	17	Admin Salaries	Direct Cost	1,315,329	10	262,066	262,066	128,919	25,686	9
10	17	Information Systems Salaries	Direct Cost	1,621,586	10	382,190	382,190	158,846	37,438	10
11	6	Information Systems - Equip Mair	Direct Cost	1,621,586	10	384,039		158,846	37,619	11
12	19	Admin Consulting,Other	Direct Cost	1,315,329	10	780,014		128,919	76,451	12
13	32	Admin - Interest Expense	Direct Cost	1,315,329	10	1,662,527		128,919	162,949	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					$ 6,989,877	$ 1,964,969		$ 685,008	25

Facility Name & ID Number Provena Cor Mariae Center # 0041046 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

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: 670 North Convent Street
City / State / Zip Code: Bourbonnais, Illinois 60914
Phone Number: (815)936-3644
Fax Number: (815-936-3238

	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			$	$		$ 655,562	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					$	$		$ 655,562	25

Facility Name & ID Number Provena Cor Mariae Center # 0041046 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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						$	$			$ 426,004	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 426,004	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$ 426,004	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 Cor Mariae Center **#** 0041046 **Report Period Beginning:** 01/01/2011 **Ending:** 12/31/2011

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 40	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.)		$ 1,274	2
3. Under or (over) accrual (line 2 minus line 1).		$ 1,234	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		$ (174)	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.		$ 1,060	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2006	1,106	8
2007	1,094	9
2008	1,157	10
2009	1,224	11
2010	1,274	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2010	$	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.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Provena Cor Mariae Center COUNTY Winnebago

FACILITY IDPH LICENSE NUMBER 0041046

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 2010 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 2010.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	153B004C 12-09-104-035	Comm SE Cor LT Imperial	$	$
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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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 Cor Mariae Center # 0041046 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? [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		1995	$ 670,894	1
2					2
3	TOTALS			$ 670,894	3

Facility Name & ID Number Provena Cor Mariae Center # 0041046 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	63			1997	$ 2,508,246	$ 62,711	40	$ 62,711	$	$ 893,437	4
5	10			2005	944,355	37,774	25	37,774		243,677	5
6											6
7											7
8											8
	Improvement Type**										
9	VARIOUS			1995	1,206,813	41,872	20	41,872		722,836	9
10	VARIOUS			1996	366,570	16,562	18	16,562		297,757	10
11	VARIOUS			1997	251,717	10,721	23	10,721		208,533	11
12	VARIOUS			1998	174,397	5,239	20	5,239		87,951	12
13	VARIOUS			1999	10,976					10,976	13
14	VARIOUS			2000	39,900					39,900	14
15	VARIOUS			2001	48,414	2,107	16	2,107		40,483	15
16	VARIOUS			2002	118,018	9,046	12	9,046		92,249	16
17	VARIOUS			2003	122,240	2,808	10	2,808		117,920	17
18	VARIOUS			2004	106,296	8,592	12	8,592		81,494	18
19	VARIOUS			2005	68,501	6,282	11	6,282		42,053	19
20	VARIOUS			2006	115,365	9,815	11	9,815		54,159	20
21	VARIOUS			2007	63,026	6,483	10	6,483		29,770	21
22	VARIOUS										22
23	TRANSFER SWITCHES			2008	34,753	4,965	7	4,965		17,376	23
24	WATER MAINBREAK PIPES			2008	3,607	361	10	361		1,263	24
25	ELEVATOR			2008	141,962	7,098	20	7,098		24,843	25
26	WATER MAINBREAK PIPES			2008	7,074	707	10	707		2,476	26
27											27
28											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 Cor Mariae Center # 0041046 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	BOILER INSTALLATION	2009	$ 16,759	$ 838	20	$ 838	$	$ 2,095	37
38	PATIO PROJECT	2009	73,176	4,878	15	4,878		10,270	38
39	FIX BOILER	2009	3,810	544	7	544		1,497	39
40	PATIO PROJECT / EXTERNAL BEAUTIFICATI	2009	131,151	6,558	20	6,558		15,621	40
41	CARPETING	2009	5,965	1,193	5	1,193		2,983	41
42	PATCHPARKING LOT	2009	18,336	2,292	8	2,292		5,730	42
43	KITCHEN HOOD WIRING	2009	2,795	280	10	280		699	43
44	PARTIAL RE-ROOF	2009	17,740	1,774	10	1,774		4,435	44
45	CARPETING FOR 9 MEDAPTS, 2SM APTS,	2009	12,466	2,493	5	2,493		6,233	45
46	**Deduction for Non-Care Assets**		(12,466)	(2,493)		(2,493)		(2,493)	46
47	INSTALL SHOWER/HARDWARE	2010	9,379	938	10	938		1,874	47
48	AUTO MATICDOOR OPENER ON SKILLED CON	2010	3,433	343	10	343		515	48
49	WATER MAINREPAIR	2010	14,831	2,119	7	2,119		4,238	49
50	NATURAL OAKVINYL FLOORINGFOR 11 RES	2010	22,480	2,248	10	2,248		3,372	50
51	ROOF INSTALLATION PEAK / NORTH STAIRW	2010	21,410	2,141	10	2,141		3,212	51
52	PATCH AREAOF WATERBREAK	2010	3,797	380	10	380		570	52
53	ELEVATOR REPAIRS	2010	38,450	1,923	20	1,923		2,211	53
54	WATER HEATER KITCHEN	2010	9,341	934	10	934		934	54
55									55
56	INFRA STRUCTURE FORWALL MOUNTED COMP	2011	5,253	131	20	263	132	131	56
57	SPRINKLER PROJECT	2011	410,205	8,204	25	16,408	8,204	8,204	57
58	PARKING LOTEXPANSION	2011	13,332	833	8	1,667	834	833	58
59	VINYL FLOORING (CORRIDOR TOSKILLED U	2011	31,880	1,594	10	3,188	1,594	1,594	59
60	CODE ALERTEXIT ALARM	2011	3,767	126	15	251	125	126	60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	**TOTAL (lines 4 thru 69)**		$ 7,189,520	$ 273,413		$ 284,302	$ 10,889	$ 3,084,034	70

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

Facility Name & ID Number Provena Cor Mariae Center # 0041046 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	$ 1,804,013	$ 156,543	$ 156,543	$	11	$ 1,101,466	71
72	Current Year Purchases	129,106	5,457	10,914	5,457	11	5,457	72
73	Fully Depreciated Assets	368,608				6	368,608	73
74	Home Office Allocation		55,262	55,262				74
75	TOTALS	$ 2,301,727	$ 217,262	$ 222,719	$ 5,457		$ 1,475,531	75

D. Vehicle Costs. (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	1991 CHEVROLET FLEETSIDE	1995	$ 14,000	$	$	$	5	$ 14,000	76
77	Plant Engineering	2000 FORDELDORADO-CAP15	2000	42,500				10	42,500	77
78										78
79										79
80	TOTALS			$ 56,500	$	$	$		$ 56,500	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)	$ 10,218,641	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 490,675	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 507,021	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 16,346	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,616,065	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 Cor Mariae Center # 0041046 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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				20,036			5
6								6
7	TOTAL				$ 20,036 **			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.	/2012	$
13.	/2013	$
14.	/2014	$

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: $ 55,866 Description: Nursing $39,242; Sup Living ($40); Dietary $269; Administration $13,182; Home Office $3213
(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 Cor Mariae Center # 0041046 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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 Cor Mariae Center | STATE OF ILLINOIS # 0041046 | Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a,3	hrs	$	6,967	$ 478,325	$	6,967	$ 478,325	1
2	Licensed Speech and Language Development Therapist	10a,3	hrs		1,327	98,624		1,327	98,624	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a,3	hrs		7,026	494,510		7,026	494,510	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				655,562		655,562	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			$	15,320	$ 1,071,459	$ 655,562	15,320	$ 1,727,021	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 Cor Mariae Center # 0041046 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2011 (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	$ 9,921,439	$	1
2	Cash-Patient Deposits	94,756		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	15,932,837		3
4	Supply Inventory (priced at)	788,723		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	202,376		7
8	Accounts Receivable (owners or related parties)	135,366		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 27,075,497	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	8,348,207		12
13	Land	6,027,432		13
14	Buildings, at Historical Cost	82,802,332		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	19,392,931		16
17	Accumulated Depreciation (book methods)	(58,282,720)		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)**	$ 58,288,182	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 85,363,679	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 5,213,946	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,164,816		28
29	Short-Term Notes Payable	65,040		29
30	Accrued Salaries Payable	3,383,504		30
31	Accrued Taxes Payable (excluding real estate taxes)	136,208		31
32	Accrued Real Estate Taxes(Sch.IX-B)	1,389,718		32
33	Accrued Interest Payable	10,520		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to Related Party	983,226		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 12,346,978	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,037,972		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	396,894		42
	Other Long-Term Liabilities(specify):			
43	Conditional Asset Retirement	438,744		43
44	Deferred Lease Payable	23,814		44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,897,424	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 14,244,402	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 71,119,277	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 85,363,679	$	48

*(See instructions.)

Facility Name & ID Number Provena Cor Mariae Center **#** 0041046 **Report Period Beginning:** 01/01/2011 **Ending:** 12/31/2011

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 74,355,616	1
2	Restatements (describe):		2
3	Transfer to Affiliates	(8,169,570)	3
4	Adj. To reconcile consolidated equity & consolidated income	3,844,635	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 70,030,681	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,005,415	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	226,484	11
12	Expenditures for Specific Purposes	(143,303)	12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 1,088,596	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)**	$ 71,119,277	24 *

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

Facility Name & ID Number Provena Cor Mariae Center # 0041046 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	$ 8,411,582	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,411,582	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,909,240	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,909,240	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	813	13
14	Non-Patient Meals	1,211	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	617,439	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	5,807	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 625,270	23
	D. Non-Operating Revenue		
24	Contributions	14,427	24
25	Interest and Other Investment Income***	9,509	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 23,936	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Purchase Rebates	261,530	28
28a	Misc Income & Gain/Loss SOFA	88,910	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 350,440	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 11,320,468	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,996,013	31
32	Health Care	4,325,170	32
33	General Administration	2,846,192	33
	B. Capital Expense		
34	Ownership	452,148	34
	C. Ancillary Expense		
35	Special Cost Centers	655,562	35
36	Provider Participation Fee	39,968	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,315,053	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,005,415	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,005,415	43

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

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

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

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

Facility Name & ID Number Provena Cor Mariae Center # 0041046 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	1,664	2,038	$ 83,997	$ 41.22	1
2	Assistant Director of Nursing	2,017	2,089	70,178	33.59	2
3	Registered Nurses	17,240	19,704	575,860	29.23	3
4	Licensed Practical Nurses	26,395	30,597	762,667	24.93	4
5	CNAs & Orderlies	68,186	75,571	905,390	11.98	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,713	4,167	70,525	16.92	8
9	Activity Director	1,936	2,080	40,304	19.38	9
10	Activity Assistants	19,802	21,223	218,860	10.31	10
11	Social Service Workers	4,880	5,347	93,064	17.40	11
12	Dietician	22	24	600	25.00	12
13	Food Service Supervisor	2,470	2,764	61,692	22.32	13
14	Head Cook					14
15	Cook Helpers/Assistants	41,561	45,221	441,791	9.77	15
16	Dishwashers					16
17	Maintenance Workers	5,788	6,279	127,464	20.30	17
18	Housekeepers	16,603	17,723	165,177	9.32	18
19	Laundry	2,773	3,015	26,813	8.89	19
20	Administrator	1,788	2,080	119,035	57.23	20
21	Assistant Administrator	3,744	4,156	61,203	14.73	21
22	Other Administrative	9,202	10,013	135,408	13.52	22
23	Office Manager	1,528	1,802	40,941	22.72	23
24	Clerical	3,709	3,990	89,597	22.46	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	3,623	3,880	114,634	29.54	32
33	Other(specify) Pastoral Care	1,940	2,088	45,407	21.75	33
34	TOTAL (lines 1 - 33)	240,584	265,851	$ 4,250,607 *	$ 15.99	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	288	$ 17,550	1,3	35
36	Medical Director	140	21,000	9,3	36
37	Medical Records Consultant	30	2,110	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	40	3,048	11,3	44
45	Social Service Consultant	4	281	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	502	$ 43,989		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 Cor Mariae Center # 0041046 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Teresa Wester-Peters	Administrator	0	$ 119,035
Administrative Staff	Admissions	0	114,634
Administrative Staff	Human Resource	0	43,301
Administrative Staff	Admin Asst	0	38,267
Administrative Staff	Receptionist	0	49,994
Administrative Staff	Office Manager	0	40,941
Administrative Staff	Asst Administrator	0	61,203
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 467,375

B. Administrative - Other

Description	Amount
Corproate Service Fee	$ 128,919
Corporate Fee	158,846
Mgmt Fee	368,400
Mngt Fee Interest	299,196
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 955,361

C. Professional Services

Vendor/Payee	Type	Amount
Legal Expense	Various	$ 284
Collection Expense	Various	279
Shredding/Storage	Various	2,233
Survey & Analytical Tools	Various	4,132
Outsourced Services	Various	530
Audit Expense	Various	(1,855)
Living Design	Various	997
Security	Various	2,030
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 8,630

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 123,531
Unemployment Compensation Insurance	32,223
FICA Taxes	309,370
Employee Health Insurance	428,906
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Life Insurance	16,199
Pension	147,551
Employee Recognition	
Executive Benefits	5,710
Employment Screenings	25,074
Home Office Allocation	218,218
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,306,782

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 38)	
Patient Background Checks 240	
Employee Recruitment	575
Dues & Subscription	12,348
Advertising & Public Relations	9,700
Home Office Allocation	7,453
Less: Public Relations Expense	( )
Non-allowable advertising	(11,923)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 18,153

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 2,058
In-State Travel	12,770
Seminar Expense	
Home Office Allocation	4,366
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 19,194

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Provena Cor Mariae Center # 0041046 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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 Cor Mariae Center** **#** **0041046** **Report Period Beginning:** **01/01/2011** **Ending:** **12/31/2011**

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Life Service Network $7,688**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **Yes** If YES, what is the capacity? **162**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **33,894** 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.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **39,968**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **1,211**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **Yes**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? **No**
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **KPMG**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.