FOR BHF USE

LL1

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.

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

I. IDPH License ID Number: 0041871

Facility Name: Provena St. Joseph Center

Address: 659 E. Jefferson Street (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
			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

IRS Exemption Code 501 C3

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 St. Joseph Center # 0041871 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	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	24,039	8,856	6,112	39,007	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	24,039	8,856	6,112	39,007	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.06%

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 4,947

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 St. Joseph Center # 0041871 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	411,474	38,047	18,715	468,236		468,236		468,236			1
2	Food Purchase		219,615		219,615		219,615	(54,800)	164,815			2
3	Housekeeping	108,483	25,301		133,784		133,784		133,784			3
4	Laundry		1,778	107,543	109,321		109,321		109,321			4
5	Heat and Other Utilities			164,966	164,966		164,966	4,857	169,823			5
6	Maintenance	139,089	25,973	77,023	242,085		242,085	64,295	306,380			6
7	Other (specify):* Pastoral Care	35,171	369	21,422	56,962		56,962	(21,422)	35,540			7
8	TOTAL General Services	694,217	311,083	389,669	1,394,969		1,394,969	(7,070)	1,387,899			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	2,314,143	150,877	13,576	2,478,596		2,478,596		2,478,596			10
10a	Therapy			484,333	484,333		484,333		484,333			10a
11	Activities	93,920	1,351	3,384	98,655		98,655	1,313	99,968			11
12	Social Services	23,642	24	310	23,976		23,976		23,976			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,431,705	152,252	513,603	3,097,560		3,097,560	1,313	3,098,873			16
	C. General Administration											
17	Administrative	285,466	17,581	744,265	1,047,312		1,047,312	(311,535)	735,777			17
18	Directors Fees											18
19	Professional Services			5,586	5,586		5,586	42,919	48,505			19
20	Dues, Fees, Subscriptions & Promotions			28,171	28,171		28,171	(9,403)	18,768			20
21	Clerical & General Office Expenses			45,080	45,080		45,080	5,380	50,460			21
22	Employee Benefits & Payroll Taxes			1,007,480	1,007,480		1,007,480	175,410	1,182,890			22
23	Inservice Training & Education			1,436	1,436		1,436	3,023	4,459			23
24	Travel and Seminar			2,748	2,748		2,748	3,313	6,061			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			104,675	104,675		104,675	(393)	104,282			26
27	Other (specify):* Bad Debt			64,525	64,525		64,525	(64,525)				27
28	TOTAL General Administration	285,466	17,581	2,003,966	2,307,013		2,307,013	(155,811)	2,151,202			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,411,388	480,916	2,907,238	6,799,542		6,799,542	(161,568)	6,637,974			29

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

Facility Name & ID Number Provena St. Joseph Center #0041871 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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			293,393	293,393		293,393	49,910	343,303			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							321,678	321,678			32
33	Real Estate Taxes			114,732	114,732		114,732		114,732			33
34	Rent-Facility & Grounds							15,204	15,204			34
35	Rent-Equipment & Vehicles			6,435	6,435		6,435	2,438	8,873			35
36	Other (specify):*											36
37	**TOTAL Ownership**			414,560	414,560		414,560	389,230	803,790			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			398,383	398,383		398,383	(212,006)	186,377			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			64,937	64,937		64,937		64,937			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			463,320	463,320		463,320	(212,006)	251,314			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,411,388	480,916	3,785,118	7,677,422		7,677,422	15,656	7,693,078			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: 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	(57,142)	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	6,831	30		9
10	Interest and Other Investment Income	(12,428)	32		10
11	Discounts, Allowances, Rebates & Refunds	(212,006)	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	(2,277)	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	(64,525)	27		24
25	Fund Raising, Advertising and Promotional	(14,751)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(308)	20		28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (356,606)		$	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)	393,684		34
35	Other- Attach Schedule	(21,422)		35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 372,262		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 15,656		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 St. Joseph Center

ID# 0041871

Report Period Beginning: 01/01/2011

Ending: 12/31/2011

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Development Misc	$ (21,422)	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**	(21,422)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Provena St. Joseph Center # 0041871 **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	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	(57,142)	2,342	0	0	0	0	0	0	0	0	0	(54,800)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	4,857	0	0	0	0	0	0	0	0	0	4,857	5
6	Maintenance	0	1,195	63,100	0	0	0	0	0	0	0	0	64,295	6
7	Other (specify):*	(21,422)	0	0	0	0	0	0	0	0	0	0	(21,422)	7
8	**TOTAL General Services**	(78,564)	8,394	63,100	0	0	0	0	0	0	0	0	(7,070)	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	1,313	0	0	0	0	0	0	0	0	0	1,313	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	1,313	0	0	0	0	0	0	0	0	0	1,313	16
	C. General Administration													
17	Administrative	0	(260,578)	(50,957)	0	0	0	0	0	0	0	0	(311,535)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	25,145	17,774	0	0	0	0	0	0	0	0	42,919	19
20	Fees, Subscriptions & Promotions	(15,059)	5,656	0	0	0	0	0	0	0	0	0	(9,403)	20
21	Clerical & General Office Expenses	0	5,380	0	0	0	0	0	0	0	0	0	5,380	21
22	Employee Benefits & Payroll Taxes	0	54,399	121,011	0	0	0	0	0	0	0	0	175,410	22
23	Inservice Training & Education	0	3,023	0	0	0	0	0	0	0	0	0	3,023	23
24	Travel and Seminar	0	3,313	0	0	0	0	0	0	0	0	0	3,313	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	(393)	0	0	0	0	0	0	0	0	0	(393)	26
27	Other (specify):*	(64,525)	0	0	0	0	0	0	0	0	0	0	(64,525)	27
28	**TOTAL General Administration**	(79,584)	(164,055)	87,828	0	0	0	0	0	0	0	0	(155,811)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(158,148)	(154,348)	150,928	0	0	0	0	0	0	0	0	(161,568)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Provena St. Joseph Center **#** 0041871 **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 D. Ownership	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)	
30	Depreciation	4,554	0	45,356	0	0	0	0	0	0	0	0	49,910	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(12,428)	0	334,106	0	0	0	0	0	0	0	0	321,678	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	15,204	0	0	0	0	0	0	0	0	15,204	34
35	Rent-Equipment & Vehicles	0	0	2,438	0	0	0	0	0	0	0	0	2,438	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(7,874)	0	397,104	0	0	0	0	0	0	0	0	389,230	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	(212,006)	0	0	0	0	0	0	0	0	0	0	(212,006)	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**	(212,006)	0	0	0	0	0	0	0	0	0	0	(212,006)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(378,028)	(154,348)	548,032	0	0	0	0	0	0	0	0	15,656	45

Facility Name & ID Number Provena St. Joseph Center # 0041871 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%	$ 2,342	$ 2,342	1
2	V	5	Utilities		Provena Life Connections	100.00%	4,857	4,857	2
3	V	6	Maintenance - Other		Provena Life Connections	100.00%	1,195	1,195	3
4	V	11	Activities-Special Events		Provena Life Connections	100.00%	1,313	1,313	4
5	V	17	Admin - Misc. Other	506,592	Provena Life Connections	100.00%	4,564	(502,028)	5
6	V	17	Administrative Salaries		Provena Life Connections	100.00%	241,450	241,450	6
7	V	19	Professional Services		Provena Life Connections	100.00%	25,145	25,145	7
8	V	20	Dues,Subscriptions		Provena Life Connections	100.00%	5,656	5,656	8
9	V	21	Clerical Supplies		Provena Life Connections	100.00%	5,380	5,380	9
10	V	22	Employee Benefits		Provena Life Connections	100.00%	54,399	54,399	10
11	V	23	Education/Conference		Provena Life Connections	100.00%	3,023	3,023	11
12	V	24	Travel		Provena Life Connections	100.00%	3,313	3,313	12
13	V	26	Insurance		Provena Life Connections	100.00%	(393)	(393)	13
14	Total			$ 506,592			$ 352,244	$ * (154,348)	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: 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%	$ 2,911	$ 2,911	15
16	V	32	Interest		Provena Life Connections	100.00%	199,614	199,614	16
17	V	34	Rent - Facility		Provena Life Connections	100.00%	15,204	15,204	17
18	V	35	Rent - Equipment		Provena Life Connections	100.00%	2,438	2,438	18
19	V	17	Admin Salaries	106,405	Provena Health Services	100.00%	80,985	(25,420)	19
20	V	22	Employee Benefits		Provena Health Services	100.00%	42,850	42,850	20
21	V	30	Depreciation		Provena Health Services	100.00%	42,445	42,445	21
22	V	19	Admin Consulting,Other		Provena Health Services	100.00%	17,774	17,774	22
23	V	17	Information Systems Salaries	131,268	Provena Health Services	100.00%	35,145	(96,123)	23
24	V	22	Information Systems Benefits		Provena Health Services	100.00%	25,873	25,873	24
25	V	17	Information Systems - Other		Provena Health Services	100.00%	23,823	23,823	25
26	V	17	Admin Salaries		Provena Health Services	100.00%	15,825	15,825	26
27	V	22	Employee Benefits		Provena Health Services	100.00%	21,200	21,200	27
28	V	17	Information Systems Salaries		Provena Health Services	100.00%	30,938	30,938	28
29	V	22	Information Systems Benefits		Provena Health Services	100.00%	31,088	31,088	29
30	V	6	Information Systems - Equip Maint		Provena Health Services	100.00%	63,100	63,100	30
31	V	32	Admin - Interest Expense		Provena Health Services	100.00%	134,492	134,492	31
32	V	39	Ancillary Services - Other	398,383	Provena Senior Services Pharmacy	100.00%	398,383		32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 636,056			$ 1,184,088	$ * 548,032	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: 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 St. Joseph Center # 0041871 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 St. Joseph Center # 0041871 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, IL60448
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	6,979,492	19	$ 32,265	$	506,592	$ 2,342	1
2	5	Utilities	Management Fee Income	6,979,492	19	66,913		506,592	4,857	2
3	6	Maintenance - Other	Management Fee Income	6,979,492	19	16,465		506,592	1,195	3
4	11	Activities-Special Events	Management Fee Income	6,979,492	19	18,086		506,592	1,313	4
5	17	Admin - Misc. Other	Management Fee Income	6,979,492	19	62,879		506,592	4,564	5
6	17	Administrative Salaries	Management Fee Income	6,979,492	19	3,326,538	3,326,538	506,592	241,450	6
7	19	Professional Services	Management Fee Income	6,979,492	19	346,433		506,592	25,145	7
8	20	Dues,Subscriptions	Management Fee Income	6,979,492	19	77,921		506,592	5,656	8
9	21	Clerical Supplies	Management Fee Income	6,979,492	19	74,124		506,592	5,380	9
10	22	Employee Benefits	Management Fee Income	6,979,492	19	749,474		506,592	54,399	10
11	23	Education/Conference	Management Fee Income	6,979,492	19	41,653		506,592	3,023	11
12	24	Travel	Management Fee Income	6,979,492	19	45,642		506,592	3,313	12
13	26	Insurance	Management Fee Income	6,979,492	19	(5,417)		506,592	(393)	13
14	30	Depreciation	Management Fee Income	6,979,492	19	40,099		506,592	2,911	14
15	32	Interest	Management Fee Income	6,979,492	19	2,750,151		506,592	199,614	15
16	34	Rent - Facility	Management Fee Income	6,979,492	19	209,473		506,592	15,204	16
17	35	Rent - Equipment	Management Fee Income	6,979,492	19	33,596		506,592	2,438	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 7,886,295	$ 3,326,538		$ 572,411	25

Facility Name & ID Number Provena St. Joseph Center # 0041871 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	106,405	$ 80,985	1
2	22	Employee Benefits	Operating Expense	1,315,329	10	529,691		106,405	42,850	2
3	30	Depreciation	Operating Expense	1,315,329	10	524,686		106,405	42,445	3
4	34	Rent Facility	Operating Expense	1,315,329	10	219,709		106,405	17,774	4
5	19	Admin Consulting,Other	Operating Expense	1,315,329	10	434,452		106,405	35,145	5
6	17	Information Systems Salaries	Operating Expense	1,621,586	10	319,617	319,617	131,268	25,873	6
7	22	Information Systems Benefits	Operating Expense	1,621,586	10	294,294		131,268	23,823	7
8	17	Information Systems - Other	Operating Expense	1,621,586	10	195,496		131,268	15,825	8
9	17	Admin Salaries	Direct Cost	1,315,329	10	262,066	262,066	106,405	21,200	9
10	17	Information Systems Salaries	Direct Cost	1,621,586	10	382,190	382,190	131,268	30,938	10
11	6	Information Systems - Equip Mair	Direct Cost	1,621,586	10	384,039		131,268	31,088	11
12	19	Admin Consulting,Other	Direct Cost	1,315,329	10	780,014		106,405	63,100	12
13	32	Admin - Interest Expense	Direct Cost	1,315,329	10	1,662,527		106,405	134,492	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		$ 565,538	25

Facility Name & ID Number Provena St. Joseph Center # 0041871 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			$	$		$ 398,383	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					$	$		$ 398,383	25

Facility Name & ID Number Provena St. Joseph Center # 0041871 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						$	$			$ 334,106	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 334,106	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$ 334,106	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:** 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.**	$	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 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 114,732	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.		$ 114,732	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	2006	8
	2007	9
	2008	10
	2009	11
	2010	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 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 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.	To be determined		$ 114,732	$ 114,732
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 114,732.00	$ 114,732.00

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 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 St. Joseph Center # 0041871 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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: 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	120		1996	1996	$ 2,500,000	$ 62,500	40	$ 62,500	$	$ 968,750	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1996							9
10	Various			1997	1,037					1,037	10
11	Various			1998	3,718					3,718	11
12	Various			1999	78,698	2,227	15	2,227		61,997	12
13	Various			2000							13
14	Various			2001	19,599	544	15	544		17,107	14
15	Various			2002	28,187	2,077	14	2,077		22,838	15
16	Various			2003	77,509	6,814	11	6,814		61,239	16
17	Various			2004	16,330	627	11	627		14,203	17
18	Various			2005	93,561	6,947	12	6,947		45,193	18
19	Various			2006	34,761	3,005	11	3,005		19,680	19
20	Various			2007	154,464	12,706	12	12,706		55,682	20
21											21
22	WIRING FORFIRE ALARMS / TIE INTO NEW			2008	46,500	2,325	20	2,325		9,300	22
23	ENTRANCE CANOPY / DRIVE			2008	3,568	357	10	357		1,427	23
24	PAINTING/PEWS OFCHURCH			2008	42,100	2,105	20	2,105		7,368	24
25	ELECTRICALWORK FORMINISTRY			2008	8,100	405	20	405		1,418	25
26	NEW BASEBOARD COVERS FOR 64RESIDENT			2008	21,020	2,102	10	2,102		7,357	26
27	DINING ROOMPAINTING			2008	9,030	753	12	753		2,634	27
28	WINDOWS FORCLF 1STFLOOR			2008	3,424	342	10	342		1,198	28
29	MOBILE CABINET			2008	2,135	213	10	213		747	29
30	FLAG POLE			2008	3,785	189	20	189		662	30
31	PARKING LOT SEAL, CONCRETE WALKWAY			2008	74,818	9,352	8	9,352		32,733	31
32	CANOPY PROJECT			2008	4,868	325	15	325		1,136	32
33	DEDUCTION FOR NON-CARE ASSETS			2008	(3,424)	(342)	-10	(342)		(1,198)	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: 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	INSTALL SPRINKLER	2009	$ 4,185	$ 209	20	$ 209	$	$ 523	37
38	COMPRESSOR	2009	5,365	447	12	447		1,118	38
39	CANOPY PROJECT	2009	57,918	3,861	15	3,861		8,862	39
40	HOT WATER EXCHANGER, EXPANSION TANK,	2009	55,826	5,583	10	5,583		13,957	40
41	ASPHALT PARKING LOT	2009	5,396	675	8	675		1,686	41
42	CARRIER 10TON CONDENSING UNIT W/ LOW	2009	6,590	439	15	439		1,098	42
43	GENERATOR LOAD	2009	2,649	530	5	530		1,325	43
44	15 SECOND DOOR MAGNETS, TRANSMITTERS,	2009	15,440	1,544	10	1,544		3,860	44
45	THIRD FL BATHROOM PAINT/TOILET	2009	17,605	1,760	10	1,760		4,401	45
46	DEDUCTION FOR NON-CARE ASSETS	2009	(17,605)	(1,760)	-10	(1,760)		(4,401)	46
47									47
48	CLF HOBAN HALL HOTWATER HEATERS AND	2010	2,750	275	10	275		413	48
49	PAINTING OFHALLWAYS IN NURSING HOME	2010	3,001	600	5	600		900	49
50	HVAC AIR DAMPER CONTROL MOTORS	2010	7,660	1,532	5	1,532		2,298	50
51	PHASE 3 FORBOILER	2010	5,100	255	20	255		383	51
52	HUMIDIFIERSYSTEM -HONEYWELL STEAM W	2010	5,960	745	8	745		1,118	52
53	CULTURE CHANGE	2010	27,077	1,805	15	1,805		2,708	53
54	PARKING LOTSEAL	2010	59,821	7,478	8	7,478		11,216	54
55	DEDUCTION FOR NON-CARE ASSETS	2010	(2,750)	(275)	-10	(275)		(413)	55
56									56
57	FIRE CODE SAFETY DOORS SYSTEM	2011	4,214	140	15	281	141	140	57
58	FIRE ALARM& SMOKEDETECTORWIRING	2011	13,175	659	10	1,318	659	659	58
59	SECURITY SYSTEM	2011	6,350	317	10	635	318	317	59
60	CARPET	2011	5,303	530	5	1,061	531	530	60
61	PAINTING	2011	3,174	317	5	635	318	317	61
62	CLF - 4 FIRE DOORS	2011	7,260	242	15	484	242	242	62
63	COVER TO EDGE OF THIRD STORY	2011	4,268	213	10	427	214	213	63
64	B WING COMPRESSOR	2011	4,976		15	332	332		64
65	DEDUCTION FOR NON-CARE ASSETS	2011	(7,260)	(242)	-15	(484)	(242)	(242)	65
66									66
67									67
68									68
69									69
70	**TOTAL (lines 4 thru 69)**		$ 3,527,233	$ 143,452		$ 145,963	$ 2,511	$ 1,389,454	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: 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	$ 1,195,172	$ 129,349	$ 129,349	$	11	$ 515,924	71
72	Current Year Purchases	61,729	4,320	8,640	4,320	9	4,320	72
73	Fully Depreciated Assets	456,854				5	456,854	73
74	Home Office Allocation		45,356	45,356				74
75	TOTALS	$ 1,713,755	$ 179,025	$ 183,345	$ 4,320		$ 977,098	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	2006 CHEVY UPLANDER(MAR	2007	$ 15,649	$ 1,956	$ 1,956	$	4	$ 15,649	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	12,039	12,039		4	18,058	79
80	TOTALS			$ 145,292	$ 13,995	$ 13,995	$		$ 115,195	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)	$ 6,786,280	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 336,472	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 343,303	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 6,831	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,481,747	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: 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				15,204			5
6								6
7	TOTAL				$ 15,204 **			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: $ 17,139 Description: Nursing $8,223; Plant Eng $43; Administration $6,435; Home Office $2,438
(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: 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 St. Joseph Center STATE OF ILLINOIS # 0041871 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		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	$	3,483	$ 239,147	$	3,483	$ 239,147	1
2	Licensed Speech and Language Development Therapist	10a,3	hrs		115	8,571		115	8,571	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a,3	hrs		3,362	236,615		3,362	236,615	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				398,383		398,383	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			$	6,960	$ 484,333	$ 398,383	6,960	$ 882,716	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: 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 St. Joseph Center **#** 0041871 **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**	4,739,318	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 70,925,364	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	110,732	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)**	$ 193,913	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 St. Joseph Center # 0041871 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	$ 6,038,380	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,038,380	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	842,119	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 842,119	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	1,027	12
13	Barber and Beauty Care	2,085	13
14	Non-Patient Meals	57,142	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	336,283	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)**	$ 396,537	23
	D. Non-Operating Revenue		
24	Contributions	290,724	24
25	Interest and Other Investment Income***	12,428	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 303,152	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Purchase Rebates	212,006	28
28a	Misc. Income/Gain/Loss SOFA	(4,040)	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 207,966	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,788,154	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,394,969	31
32	Health Care	3,097,560	32
33	General Administration	2,307,013	33
	B. Capital Expense		
34	Ownership	414,560	34
	C. Ancillary Expense		
35	Special Cost Centers	398,383	35
36	Provider Participation Fee	64,937	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,677,422	40
41	**Income before Income Taxes (line 30 minus line 40)****	110,732	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 110,732	43

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

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

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

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

Facility Name & ID Number Provena St. Joseph Center # 0041871 Report Period Beginning: 01/01/2011 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	1,680	2,080	$ 80,518	$ 38.71	1
2	Assistant Director of Nursing	1,672	2,080	66,686	32.06	2
3	Registered Nurses	15,717	17,398	454,514	26.12	3
4	Licensed Practical Nurses	22,390	25,576	552,477	21.60	4
5	CNAs & Orderlies	78,581	88,180	1,014,561	11.51	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,967	5,516	72,413	13.13	8
9	Activity Director	1,904	2,080	32,254	15.51	9
10	Activity Assistants	5,807	6,268	59,982	9.57	10
11	Social Service Workers	1,852	2,080	23,862	11.47	11
12	Dietician	14	16	400	25.00	12
13	Food Service Supervisor	1,884	2,080	46,210	22.22	13
14	Head Cook					14
15	Cook Helpers/Assistants	34,586	37,485	354,128	9.45	15
16	Dishwashers					16
17	Maintenance Workers	9,642	10,470	141,160	13.48	17
18	Housekeepers	10,714	11,866	107,264	9.04	18
19	Laundry					19
20	Administrator	1,940	2,143	77,352	36.10	20
21	Assistant Administrator					21
22	Other Administrative	8,206	8,829	129,425	14.66	22
23	Office Manager					23
24	Clerical	5,389	6,405	83,589	13.05	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	3,932	4,327	78,689	18.19	32
33	Other(specify) Pastoral Care	1,260	1,409	35,904	25.48	33
34	TOTAL (lines 1 - 33)	212,137	236,288	$ 3,411,388 *	$ 14.44	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	243	$ 14,783	1,3	35
36	Medical Director	80	12,000	9,3	36
37	Medical Records Consultant	43	3,004	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	310	11,3	44
45	Social Service Consultant	7	310	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	380	$ 30,407		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: 01/01/2011 Ending: 12/31/2011

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Michelle Lindeman	Administrator	0	$ 77,352
Adminstrative Staff	Bookkeeper	0	38,009
Adminstrative Staff	Admissions	0	78,689
Adminstrative Staff	Receptionist	0	47,885
Adminstrative Staff	Human Resources	0	43,531
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 285,466

B. Administrative - Other

Description	Amount
Corp Service Fee	$ 106,405
Corp Service IS Fee	131,268
Mgmt Fee	304,296
Mgmt Fee Interest	202,296
TOTAL (agree to Schedule V, line 17, col. 3)	$ 744,265
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Survey & Analytical Tools	Various	$ 3,332
Outsourced Services	Various	2,215
Living Design/Starfish Ventures	Various	1,895
Audit	Various	(1,856)
Legal	Various	0
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 5,586

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 101,993
Unemployment Compensation Insurance	25,752
FICA Taxes	244,399
Employee Health Insurance	454,694
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Life Insurance	14,696
Pension	138,847
Employee Recognition	877
Executive Benefits	5,479
Employee Screenings	20,743
Home Office Allocation	175,410
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,182,890

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 20)	
Patient Background Checks 241	
Employee Recruitment	2,082
Dues & Subscriptions	11,187
Advertising & Public Relations	14,902
Home Office Allocation	5,656
Less: Public Relations Expense	( )
Non-allowable advertising	(14,751)
Yellow page advertising	(308)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 18,768

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	2,748
Seminar Expense	
Home Office Allocation	3,313
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,061

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Provena St. Joseph Center # 0041871 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 St. Joseph Center # 0041871 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 Servies Network $6037.42**

(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. $ **43,684** 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. $ **64,937**
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. $ **57,142**

(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.