

Facility Name & ID Number PROVENA OUR LADY OF VICTORY

0041723 Report Period Beginning: 01/01/01 Ending: 12/31/01

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 N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>55</u>	Skilled (SNF)	<u>55</u>	<u>20,075</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>52</u>	Intermediate (ICF)	<u>52</u>	<u>18,980</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>107</u>	TOTALS	<u>107</u>	<u>39,055</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF		<u>704</u>	<u>2,339</u>	<u>3,043</u>	8
9	SNF/PED					9
10	ICF	<u>28,852</u>	<u>4,679</u>		<u>33,531</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>28,852</u>	<u>5,383</u>	<u>2,339</u>	<u>36,574</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.65%

D. How many bed-hold days during this year were paid by Public Aid? 221 (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)

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

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

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

I. On what date did you start providing long term care at this location?
Date started 11/16/81

J. Was the facility purchased or leased after January 1, 1978?
YES Date 11/16/81 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 9 and days of care provided 2,339

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 12/31/01 Fiscal Year: 12/31/01

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

Facility Name & ID Number PROVENA OUR LADY OF VICTORY # 0041723 Report Period Beginning: 01/01/01 Ending: 12/31/01

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	195,347	24,766	10,798	230,911		230,911		230,911		1
2	Food Purchase		146,369		146,369		146,369		146,369		2
3	Housekeeping	101,139	19,988	1,260	122,387		122,387	634	123,021		3
4	Laundry	49,528	18,074	1,484	69,086		69,086		69,086		4
5	Heat and Other Utilities			94,465	94,465		94,465	(1,740)	92,725		5
6	Maintenance	52,562	4,294	47,475	104,331		104,331	512	104,843		6
7	Other (specify):*										7
8	TOTAL General Services	398,576	213,491	155,482	767,549		767,549	(594)	766,955		8
	B. Health Care and Programs										
9	Medical Director			6,500	6,500		6,500		6,500		9
10	Nursing and Medical Records	1,276,759	116,766	609,022	2,002,547		2,002,547	4,252	2,006,799		10
10a	Therapy	24,472			24,472		24,472		24,472		10a
11	Activities	55,821	2,989	115	58,925		58,925		58,925		11
12	Social Services	69,280	272	4,019	73,571		73,571	1,939	75,510		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):* Pastoral Care							1,639	1,639		15
16	TOTAL Health Care and Programs	1,426,332	120,027	619,656	2,166,015		2,166,015	7,830	2,173,845		16
	C. General Administration										
17	Administrative	46,019		181,800	227,819		227,819	(160,129)	67,690		17
18	Directors Fees										18
19	Professional Services			51,001	51,001		51,001	5,958	56,959		19
20	Dues, Fees, Subscriptions & Promotions			21,515	21,515		21,515	(7,371)	14,144		20
21	Clerical & General Office Expenses	100,353	14,429	84,694	199,476		199,476	(40,379)	159,097		21
22	Employee Benefits & Payroll Taxes			408,894	408,894		408,894	(5,108)	403,786		22
23	Inservice Training & Education							6,212	6,212		23
24	Travel and Seminar			9,859	9,859		9,859	1,873	11,732		24
25	Other Admin. Staff Transportation			1,216	1,216		1,216	1,463	2,679		25
26	Insurance-Prop.Liab.Malpractice			14,082	14,082		14,082	427	14,509		26
27	Other (specify):*							13,529	13,529		27
28	TOTAL General Administration	146,372	14,429	773,061	933,862		933,862	(183,524)	750,338		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,971,280	347,947	1,548,199	3,867,426		3,867,426	(176,288)	3,691,138		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 OUR LADY OF VICTORY**

#0041723

Report Period Beginning:

01/01/01

Ending:

12/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			255,100	255,100		255,100	3,769	258,869			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							116,688	116,688			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds							4,904	4,904			34
35	Rent-Equipment & Vehicles			7,351	7,351		7,351		7,351			35
36	Other (specify):*											36
37	TOTAL Ownership			262,451	262,451		262,451	125,361	387,812			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		453,394	159,282	612,676		612,676		612,676			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			58,583	58,583		58,583		58,583			42
43	Other (specify):*	31,559	1,785	8,915	42,259		42,259	(42,259)	0			43
44	TOTAL Special Cost Centers	31,559	455,179	226,780	713,518		713,518	(42,259)	671,259			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,002,839	803,126	2,037,430	4,843,395		4,843,395	(93,187)	4,750,208			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(2,064)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	3,769	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(65)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(76,555)	21		24
25	Fund Raising, Advertising and Promotional	(7,980)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(49,074)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (131,969)		\$	30

OHF 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	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	38,782		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 38,782		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (93,187)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4
		Yes	No	Amount	Reference
38	Medically Necessary Transport.			\$	38
39					39
40	Gift and Coffee Shops				40
41	Barber and Beauty Shops				41
42	Laboratory and Radiology				42
43	Prescription Drugs				43
44	Exceptional Care Program				44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	TOTAL (C): (sum of lines 38-46)			\$	47

NON-ALLOWABLE EXPENSES	Amount	Sch. V Line	Reference
1 Non-Allowable Executive Benefits	\$ 15,000	22	1
2 Non-Allowable Marketing Related Expense	(10,700)	43	2
3 Non-Allowable Marketing Related Salary	(31,559)	43	3
4 Out-of-Period Legal Fees	(1,129)	19	4
5 Non-allowable Seminar Expense	(253)	24	5
6 Undocumented Professional Service	(325)	19	6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
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89			89
90			90
91			91

STATE OF ILLINOIS

Summary A

Facility Name & ID Number PROVENA OUR LADY OF VICTORY# 0041723

Report Period Beginning:

01/01/01

Ending:

12/31/01

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary													1
2	Food Purchase													2
3	Housekeeping			634									634	3
4	Laundry													4
5	Heat and Other Utilities	(2,064)		324									(1,740)	5
6	Maintenance			512									512	6
7	Other (specify):*													7
8	TOTAL General Services	(2,064)		1,470									(594)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			4,252									4,252	10
10a	Therapy													10a
11	Activities													11
12	Social Services			1,939									1,939	12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*			1,639									1,639	15
16	TOTAL Health Care and Programs			7,830									7,830	16
	C. General Administration													
17	Administrative			(160,129)									(160,129)	17
18	Directors Fees													18
19	Professional Services	(1,454)		7,412									5,958	19
20	Fees, Subscriptions & Promotions	(8,045)		674									(7,371)	20
21	Clerical & General Office Expenses	(76,555)		36,176									(40,379)	21
22	Employee Benefits & Payroll Taxes	(5,108)											(5,108)	22
23	Inservice Training & Education			6,212									6,212	23
24	Travel and Seminar	(253)		2,126									1,873	24
25	Other Admin. Staff Transportation			1,463									1,463	25
26	Insurance-Prop.Liab.Malpractice			427									427	26
27	Other (specify):*			13,529									13,529	27
28	TOTAL General Administration	(91,414)		(92,110)									(183,524)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(93,478)		(82,810)									(176,288)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number PROVENA OUR LADY OF VICTORY# 0041723

Report Period Beginning:

01/01/01

Ending:

12/31/01

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	3,769											3,769	30
31	Amortization of Pre-Op. & Org.													31
32	Interest			116,688									116,688	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds			4,904									4,904	34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*													36
37	TOTAL Ownership	3,769		121,592									125,361	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(42,259)											(42,259)	43
44	TOTAL Special Cost Centers	(42,259)											(42,259)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(131,969)		38,782									(93,187)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Board of Directors attached		See attached		See attached		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	3 HOUSEKEEPING	\$	PROVENA SENIOR SERVICES	100.00%	\$ 634	\$	634	15
16	V	5 UTILITIES		PROVENA SENIOR SERVICES	100.00%	324		324	16
17	V	6 REPAIRS AND MAINT.		PROVENA SENIOR SERVICES	100.00%	512		512	17
18	V	10 NURSING		PROVENA SENIOR SERVICES	100.00%	4,252		4,252	18
19	V	12 SOCIAL SERVICES		PROVENA SENIOR SERVICES	100.00%	1,939		1,939	19
20	V	15 EMPLOYEE BENEFITS		PROVENA SENIOR SERVICES	100.00%	1,639		1,639	20
21	V	17 ADMINISTRATIVE	181,800	PROVENA SENIOR SERVICES	100.00%	21,671		(160,129)	21
22	V	19 PROFESSIONAL FEES		PROVENA SENIOR SERVICES	100.00%	7,412		7,412	22
23	V	20 DUES,SUBSCRIPTIONS		PROVENA SENIOR SERVICES	100.00%	674		674	23
24	V	21 CLERICAL		PROVENA SENIOR SERVICES	100.00%	36,176		36,176	24
25	V	23 INSERVICE TRAINING		PROVENA SENIOR SERVICES	100.00%	6,212		6,212	25
26	V	24 SEMINARS		PROVENA SENIOR SERVICES	100.00%	2,126		2,126	26
27	V	25 ADMIN. STAFF TRAVEL		PROVENA SENIOR SERVICES	100.00%	1,463		1,463	27
28	V	26 INSURANCE		PROVENA SENIOR SERVICES	100.00%	427		427	28
29	V	27 EMPLOYEE BENEFITS		PROVENA SENIOR SERVICES	100.00%	13,529		13,529	29
30	V	32 INTEREST-DIRECT ALLOCATION		PROVENA SENIOR SERVICES	100.00%	116,688		116,688	30
31	V	34 RENT		PROVENA SENIOR SERVICES	100.00%	4,904		4,904	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 181,800			\$ 220,582	\$ *	38,782	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	10 PHARMACY-STOCK ITEMS	\$ 5,500	PROVENA SENIOR SERVICES PHARMACY	100.00%	\$ 5,500	\$
16	V	39 PHARMACY	443,453	PROVENA SENIOR SERVICES PHARMACY	100.00%	443,453	
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 448,953			\$ 448,953	\$ *

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	19 COMPUTER	\$ 49,111	PROVENA HEALTH	100.00%	\$ 49,111	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 49,111			\$ 49,111	\$ *	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

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

Facility Name & ID Number PROVENA OUR LADY OF VICTORY # 0041723 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								\$		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 OUR LADY OF VICTORY

0041723

Report Period Beginning:

01/01/01

Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number PROVENA OUR LADY OF VICTORY

0041723

Report Period Beginning:

01/01/01

Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

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

Name of Related Organization PROVENA SENIOR SERVICES
 Street Address 200 E. COURT STREET, SUITE 200
 City / State / Zip Code KANKAKEE, IL. 60901
 Phone Number (815) 928-6851
 Fax Number (847) 928-6160

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	MGT FEE INCOME	5,221,293	17	\$ 18,200	\$ 181,800	\$ 634	1
2	5	UTILITIES	MGT FEE INCOME	5,221,293	17	9,294	181,800	324	2
3	6	REPAIRS AND MAINT.	MGT FEE INCOME	5,221,293	17	14,705	181,800	512	3
4	10	NURSING	MGT FEE INCOME	5,221,293	17	122,116	181,800	4,252	4
5	12	SOCIAL SERVICES	MGT FEE INCOME	5,221,293	17	55,680	181,800	1,939	5
6	15	EMPLOYEE BENEFITS	MGT FEE INCOME	5,221,293	17	47,063	181,800	1,639	6
7	17	ADMINISTRATIVE	MGT FEE INCOME	5,221,293	17	622,384	181,800	21,671	7
8	19	PROFESSIONAL FEES	MGT FEE INCOME	5,221,293	17	212,867	181,800	7,412	8
9	20	DUES,SUBSCRIPTIONS	MGT FEE INCOME	5,221,293	17	19,371	181,800	674	9
10	21	CLERICAL	MGT FEE INCOME	5,221,293	17	1,038,965	181,800	36,176	10
11	23	INSERVICE TRAINING	MGT FEE INCOME	5,221,293	17	178,422	181,800	6,212	11
12	24	SEMINARS	MGT FEE INCOME	5,221,293	17	61,070	181,800	2,126	12
13	25	ADMIN. STAFF TRAVEL	MGT FEE INCOME	5,221,293	17	42,016	181,800	1,463	13
14	26	INSURANCE	MGT FEE INCOME	5,221,293	17	12,250	181,800	427	14
15	27	EMPLOYEE BENEFITS	MGT FEE INCOME	5,221,293	17	388,552	181,800	13,529	15
16	32	INTEREST-DIRECT ALLOCAT	DIRECT ALLOCATION			2,258,265		116,688	16
17	34	RENT	MGT FEE INCOME	5,221,293	17	140,857	181,800	4,904	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 5,242,077	\$ 1,758,540	\$ 220,582	25

Facility Name & ID Number PROVENA OUR LADY OF VICTORY

0041723

Report Period Beginning:

01/01/01

Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

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

Name of Related Organization PROVENA SENIOR SERVICES PHARMACY
 Street Address 1475 HARVARD DRIVE
 City / State / Zip Code KANKAKEE, IL 60901
 Phone Number (815)928-6141
 Fax Number (815)946-3238

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	10	PHARMACY-STOCK ITEMS	DIRECT ALLOCATION					5,500	1
2	39	PHARMACY	DIRECT ALLOCATION					443,453	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				\$	\$		\$ 448,953	25

Facility Name & ID Number PROVENA OUR LADY OF VICTORY

0041723

Report Period Beginning:

01/01/01

Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

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

Name of Related Organization PROVENA HEALTH
 Street Address 9223 WEST ST. FRANCIS ROAD
 City / State / Zip Code FRANKFURT, IL 60423
 Phone Number (815)469-4888
 Fax Number (815)469-4864

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	19	COMPUTER	DIRECT ALLOCATION					49,111	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				\$	\$		\$ 49,111	25

Facility Name & ID Number PROVENA OUR LADY OF VICTORY

0041723

Report Period Beginning:

01/01/01

Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number PROVENA OUR LADY OF VICTORY

0041723

Report Period Beginning: 01/01/01

Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number PROVENA OUR LADY OF VICTORY

0041723

Report Period Beginning:

01/01/01

Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number PROVENA OUR LADY OF VICTORY

0041723

Report Period Beginning: 01/01/01

Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number PROVENA OUR LADY OF VICTORY

0041723

Report Period Beginning: 01/01/01

Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number PROVENA OUR LADY OF VICTORY

0041723

Report Period Beginning:

01/01/01

Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number **PROVENA OUR LADY OF VICTORY**

0041723

Report Period Beginning:

01/01/01

Ending:

12/31/01

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**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1										1										
2										2										
3										3										
4										4										
5										5										
Working Capital																				
6										6										
7										7										
8										8										
9	TOTAL Facility Related					\$	\$		\$	9										
B. Non-Facility Related*																				
10	See Supplemental Schedule									116,688	10									
11										11										
12										12										
13										13										
14	TOTAL Non-Facility Related					\$	\$		\$	116,688	14									
15	TOTALS (line 9+line14)					\$	\$		\$	116,688	15									

* 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 OUR LADY OF VICTORY

0041723

Report Period Beginning:

01/01/01

Ending:

12/31/01

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	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
1	Interest Expense Alloc.						\$	\$				\$	1					
2	- Peoria Senior Services	X											116,688	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							\$	\$				\$	116,688	21				

Facility Name & ID Number **PROVENA OUR LADY OF VICTORY**

0041723

Report Period Beginning:

01/01/01

Ending:

12/31/01

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2000 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 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	1996	8	
	1997	9	
	1998	10	
	1999	11	
	2000	12	
			FOR OHF USE ONLY
	13	FROM R. E. TAX STATEMENT FOR 2000 \$	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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME PROVENA OUR LADY OF VICTORY COUNTY KANKAKEE

FACILITY IDPH LICENSE NUMBER 0041723

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 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 2000.

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

B. Real Estate Tax Cost Allocations

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

If YES, attach an explanation & 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 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number PROVENA OUR LADY OF VICTORY

0041723

Report Period Beginning:

01/01/01

Ending:

12/31/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 43,172 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Nursing Home</u>		<u>1981</u>	\$ <u>135,000</u>	<u>1</u>
2	<u>Related Party</u>		<u>1985</u>	<u>3,003</u>	<u>2</u>
3	TOTALS			\$ 138,003	3

Facility Name & ID Number **PROVENA OUR LADY OF VICTORY**

0041723

Report Period Beginning:

01/01/01

Ending:

12/31/01

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4			1981	\$ 507,112	\$ 20,284	35	\$ 20,284	\$ 0	\$ 409,063	4
5			1984	726,964	29,079	35	29,079	(0)	522,979	5
6			1987	60,646	2,956	35	2,956	(0)	42,283	6
7			1995	2,355,336	59,224	35	59,224	0	375,336	7
8										8
Improvement Type**										
9	Various		1982	95,473	3,819	20	3,819	(0)	74,470	9
10	Various		1985	300	-	20	-		300	10
11	Various		1987	33,355	2,224	20	2,224	(0)	32,244	11
12	Various		1988	12,127	808	20	808	(0)	10,934	12
13	Various		1989	1,046	70	20	70	(0)	802	13
14	Various		1990	90,796	6,053	20	6,053	0	69,610	14
15	Various		1991	21,073	1,054	20	1,054	(0)	21,073	15
16	Various		1992	20,449	1,437	20	1,437	0	13,352	16
17	Various		1994	3,258	267	20	267	(0)	2,958	17
18	Various		1995	161,577	5,196	20	5,196	0	42,230	18
19	Various		1996	179,046	5,848	20	5,848	0	33,482	19
20	Various		1997	98,522	24,721	20	24,721	0	110,527	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

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

See Page 12A, Line 70 for total

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

Facility Name & ID Number PROVENA OUR LADY OF VICTORY# 0041723

Report Period Beginning:

01/01/01

Ending:

12/31/01**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 4,367,080	\$ 163,040		\$ 163,040	\$ 0	\$ 1,761,643	1
2	DESC: LEXAN 33 1/2 X 39 7/8 X 1/8"	1998	663	133	20	133		464	2
3	DESC: AUTOMATIC FIRE PROTECTION	1998	2,641	528	20	528		1,849	3
4	DESC: SPRINKLER REPAIR	1998	1,641	328	20	328		1,149	4
5	DESC: CHAIR MOLDING,DOOR KNOBS,HINGE	1998	973	195	20	195		681	5
6	DESC: HEATING/COOLING UNIT (2)	1998	1,770	354	20	354		1,239	6
7	DESC: HEATING/COOLING UNITS (3)	1998	2,655	531	20	531		1,859	7
8	DESC: WALLGUARDS AND END CAPS (EGGSH	1998	1,941	388	20	388		1,358	8
9	DESC: HANDRAILS	1998	3,328	666	20	666		2,329	9
10	DESC: WIRING & KEYPADS INSTALLATION	1998	1,650	330	20	330		1,155	10
11	DESC: SANITARY SEWER INSTALLATION	1998	11,948	1,707	20	1,707		5,974	11
12	DESC: CIMARRON (7), HANDRAIL MOUNTIN	1998	160	32	20	32		112	12
13	DESC: DELAYED EGRESS MAGNETIC LOCKIN	1998	18,820	3,764	20	3,764		13,174	13
14	DESC: CAST BRONZE PLAQUE	1998	98	20	20	20		69	14
15	1998 DIFFERENTIAL ADJUST	1998	(12,045)		20				15
16	DESC: VENTING FOR OXYGEN STORAGE ROO	1999	1,390	278	20	278		695	16
17	DESC: A-WING DOORS	1999	10,267	1,027	20	1,027		2,567	17
18	DESC: PAINT WALLS, DORRS AND FRAMES	1999	9,735	3,245	20	3,245		8,113	18
19	DESC: PAINT & WALLPAPER (11 ROOMS)	1999	3,245	649	20	649		1,623	19
20	DESC: WALLGUARD RETAINER ASSEMBLY	1999	1,278	256	20	256		639	20
21	DESC: CRYSTAL JADE KICKPLATES (17)	1999	956	191	20	191		478	21
22	DESC: PAINT WALLS, DOORS, ETC	1999	7,200	1,440	20	1,440		3,600	22
23	DESC: SPRING RAIN WHTMESH QUARTZ (22	1999	1,275	255	20	255		638	23
24	DESC: ELECTRICAL CIRCUIT RELOCATION	1999	2,660	380	20	380		950	24
25	DESC: WALLGUARD ALUMINUM RETAINER AS	1999	1,748	583	20	583		1,457	25
26	DESC: ALUMINUM HANDRAIL RETAINER (11	1999	1,937	646	20	646		1,614	26
27	DESC: UNDERGROUND TANK REMOVAL	1999	32,383	2,159	20	2,159		5,397	27
28	1999 DIFFERENTIAL ADJUST	1999	(32,384)		20				28
29	DESC: CARPET WEAVERS - A WING	2000	5,206	1,041	20	1,041		1,562	29
30	DESC: CEILING PATCH	2000	1,502	300	20	300		451	30
31	DESC: COMMON AREA ASSESSMENT - OLV	2000	2,743	549	20	549		823	31
32	DESC: RGB MAJOR BUILDING CONSULTING	2000	5,712	571	20	571		857	32
33	DESC: ROOM ID SIGNS	2000	1,273	182	20	182		273	33
34	TOTAL (lines 1 thru 33)		\$ 4,461,449	\$ 185,766		\$ 185,766	\$ 0	\$ 1,824,788	34

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 4,461,449	\$ 185,766		\$ 185,766	\$ 0	\$ 1,824,788	1
2	DESC: DICK'S ASPHALT SERVICE	2000	8,300	830	20	830		1,245	2
3	DESC: WATER SERVICE	2001	7,950	795	20	795		795	3
4	DESC: NATURAL GAS WATER HEATER - A O	2001	3,225	403	20	403		403	4
5	DESC: WATER HEATER (A O SMITH)	2001	3,810	191	20	191		191	5
6	DESC: SPRINKLER REPLACEMENT	2001	662	66	20	66		66	6
7	DESC: AIR COMPRESSOR & SPRINKLER REP	2001	1,868	187	20	187		187	7
8	DESC: REPLACE RESIDENT ROOM "THROUGH	2001	1,335	67	20	67		67	8
9	DESC: SPRINKLER SYSTEM	2001	76,441	3,822	20	3,822		3,822	9
10	DESC: LAUNDRY ROOM SINK	2001	6,500	650	20	650		650	10
11	DESC: RGB MAJOR BUILDING CONSULTING	2001	495	50	20	50		50	11
12	DESC: SPRINKLER SYSTEM	2001	4,904	490	20	490		490	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	TOTAL (lines 1 thru 33)		\$ 4,576,939	\$ 193,316		\$ 193,316	\$ 0	\$ 1,832,754	34

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

Facility Name & ID Number **PROVENA OUR LADY OF VICTORY**

0041723

Report Period Beginning:

01/01/01

Ending:

12/31/01

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 4,576,939	\$ 193,316		\$ 193,316	\$ 0	\$ 1,832,754	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
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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	TOTAL (lines 1 thru 33)		\$ 4,576,939	\$ 193,316		\$ 193,316	\$ 0	\$ 1,832,754	34

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

Facility Name & ID Number **PROVENA OUR LADY OF VICTORY**

0041723

Report Period Beginning:

01/01/01

Ending:

12/31/01

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 4,576,939	\$ 193,316		\$ 193,316	\$ 0	\$ 1,832,754	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
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,576,939	\$ 193,316		\$ 193,316	\$ 0	\$ 1,832,754	34

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

Facility Name & ID Number **PROVENA OUR LADY OF VICTORY**

0041723

Report Period Beginning:

01/01/01

Ending:

12/31/01

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 4,576,939	\$ 193,316		\$ 193,316	\$ 0	\$ 1,832,754	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
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,576,939	\$ 193,316		\$ 193,316	\$ 0	\$ 1,832,754	34

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

Facility Name & ID Number **PROVENA OUR LADY OF VICTORY**

0041723

Report Period Beginning:

01/01/01

Ending:

12/31/01

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 4,576,939	\$ 193,316		\$ 193,316	\$ 0	\$ 1,832,754	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
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,576,939	\$ 193,316		\$ 193,316	\$ 0	\$ 1,832,754	34

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

Facility Name & ID Number **PROVENA OUR LADY OF VICTORY**

0041723

Report Period Beginning:

01/01/01

Ending:

12/31/01

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$ 4,576,939	\$ 193,316		\$ 193,316	\$ 0	\$ 1,832,754	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
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,576,939	\$ 193,316		\$ 193,316	\$ 0	\$ 1,832,754	34

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

Facility Name & ID Number **PROVENA OUR LADY OF VICTORY**

0041723

Report Period Beginning:

01/01/01

Ending:

12/31/01

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 4,576,939	\$ 193,316		\$ 193,316	\$ 0	\$ 1,832,754	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
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,576,939	\$ 193,316		\$ 193,316	\$ 0	\$ 1,832,754	34

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

Facility Name & ID Number **PROVENA OUR LADY OF VICTORY**

0041723

Report Period Beginning:

01/01/01

Ending:

12/31/01

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
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

*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-REP, Line 70 for total

Facility Name & ID Number PROVENA OUR LADY OF VICTORY

0041723

Report Period Beginning:

01/01/01

Ending:

12/31/01

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								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)		\$	\$	\$	\$	\$	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 331,120	\$ 56,163	\$ 58,126	\$ 1,963	10	\$ 217,556	71
72	Current Year Purchases	21,910		1,806	1,806	10	1,806	72
73	Fully Depreciated Assets	3,971				10	3,971	73
74								74
75	TOTALS	\$ 357,001	\$ 56,163	\$ 59,932	\$ 3,769		\$ 223,332	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		1999 FORD ELDORADO (CAPA	1999	\$ 44,910	\$ 5,614	\$ 5,614	\$ (0)	5	\$ 14,034	76
77										77
78										78
79										79
80	TOTALS			\$ 44,910	\$ 5,614	\$ 5,614	\$ (0)		\$ 14,034	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)	\$ 5,116,853	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 255,093	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 258,862	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 3,769	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,070,120	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Allocation - Provena Senior Services				4,904			5
6								6
7	TOTAL				\$ 4,904			7

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 7,351 Description: See attached

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning _____
Ending _____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	<u>/2002</u>	\$ _____
13.	<u>/2003</u>	\$ _____
14.	<u>/2004</u>	\$ _____

* 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 OUR LADY OF VICTORY # 0041723 Report Period Beginning: 01/01/01 Ending: 12/31/01
 XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
---	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		Contract	Total
		1	2		
		Drop-outs	Completed		
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	Nurse Aide 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 aides from other facilities.

\$ _____

D. NUMBER OF AIDES 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 aide 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 aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides 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 aides.

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

	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	39 - 03	hrs	\$		\$ 58,459	\$		\$ 58,459	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			13,076			13,076	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			87,747			87,747	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescripts				443,452		443,452	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):						9,942		9,942	13
14	TOTAL			\$		\$ 159,282	\$ 453,394		\$ 612,676	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 nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number **PROVENA OUR LADY OF VICTORY**# **0041723**Report Period Beginning: **01/01/01**

Ending:

12/31/01**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/01**

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 3,989,309	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	11,599,943		3
4	Supply Inventory (priced at)	447,185		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	424,582		7
8	Accounts Receivable (owners or related parties)	130,474		8
9	Other(specify): See supplemental schedule	457,513		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 17,049,006	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	7,516,166		12
13	Land	7,818,584		13
14	Buildings, at Historical Cost	69,593,771		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	12,395,931		16
17	Accumulated Depreciation (book methods)	(33,036,528)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	72,837		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See supplemental schedule	5,331,935		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 69,692,696	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 86,741,702	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,713,452	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	494,877		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	2,661,893		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	11,659		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See supplemental schedule	636,912		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 5,518,793	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule	44,263,363		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 44,263,363	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 49,782,156	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 36,959,546	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 86,741,702	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 34,695,680	1
2	Restatements (describe):		2
3	Adjustment to Reconcile Consolidated Opening Equity	2,375,410	3
4	and Consolidated Net Income to Nursing Facility		4
5	Amounts		5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 37,071,090	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(111,544)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		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)	\$ (111,544)	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)	\$ 36,959,546	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number **PROVENA OUR LADY OF VICTORY**# **0041723**Report Period Beginning: **01/01/01**

Ending:

12/31/01**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.****Note: This schedule should show gross revenue and expenses. Do not net revenue against expense**

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,807,653	1
2	Discounts and Allowances for all Levels	(51,608)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,756,045	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	328,291	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 328,291	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	619,805	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)	\$ 619,805	23
D. Non-Operating Revenue			
24	Contributions	22,987	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 22,987	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See supplemental schedule</u>	4,723	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 4,723	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,731,851	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	767,549	31
32	Health Care	2,166,015	32
33	General Administration	933,862	33
B. Capital Expense			
34	Ownership	262,451	34
C. Ancillary Expense			
35	Special Cost Centers	654,935	35
36	Provider Participation Fee	58,583	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,843,395	40
41	Income before Income Taxes (line 30 minus line 40)**	(111,544)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (111,544)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? not complete 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 OUR LADY OF VICTORY

0041723

Report Period Beginning: 01/01/01

Ending:

12/31/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,005	1,155	\$ 31,273	\$ 27.08	1
2	Assistant Director of Nursing	1,155	1,294	28,786	22.25	2
3	Registered Nurses	11,501	14,137	263,961	18.67	3
4	Licensed Practical Nurses	18,787	25,290	418,651	16.55	4
5	Nurse Aides & Orderlies	39,751	49,346	534,088	10.82	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,801	2,102	24,472	11.64	8
9	Activity Director	1,868	2,216	28,235	12.74	9
10	Activity Assistants	3,095	3,463	27,586	7.97	10
11	Social Service Workers	5,462	6,313	69,280	10.97	11
12	Dietician					12
13	Food Service Supervisor	1,920	2,080	27,632	13.28	13
14	Head Cook	2,722	3,435	36,043	10.49	14
15	Cook Helpers/Assistants	7,534	8,979	70,451	7.85	15
16	Dishwashers	9,730	9,942	61,221	6.16	16
17	Maintenance Workers	4,255	4,706	52,562	11.17	17
18	Housekeepers	12,256	14,017	101,139	7.22	18
19	Laundry	5,497	6,313	49,528	7.85	19
20	Administrator	1,468	1,640	46,019	28.06	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,624	10,105	100,353	9.93	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)	2,115	2,324	31,559	13.58	33
34	TOTAL (lines 1 - 33)	139,546	168,857	\$ 2,002,839 *	\$ 11.86	34

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	216	\$ 10,798	01-03	35
36	Medical Director	Monthly	6,500	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	1,741	10-03	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	Monthly	115	11-03	44
45	Social Service Consultant	16	708	12-03	45
46	Other(specify)				46
47					47
48	Pastoral Service	Monthly	3,311	12-03	48
49	TOTAL (lines 35 - 48)	232	\$ 23,173		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	3,244	\$ 140,496	10-03	50
51	Licensed Practical Nurses	2,309	76,241	10-03	51
52	Nurse Aides	19,479	390,544	10-03	52
53	TOTAL (lines 50 - 52)	25,032	\$ 607,281		53

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

** See instructions.

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	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
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 OUR LADY OF VICTORY**# **0041723**Report Period Beginning: **01/01/01**Ending: **12/31/01****XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Life Service Network \$4,359
- (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? _____
- (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? _____
- (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? 10 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 Line _____
- (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. _____
- (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 of Public Aid during this cost report period. \$ 58,583
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 of Public Aid, 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 benefit: on Schedule V. \$ 0 Has any meal income been offset against related costs? _____ Indicate the amount. \$ _____
- (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. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 100%ln14
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
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. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: KPMG The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Report not available at time of filing
- (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 \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees