

		FOR OFF USE				

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

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

I. IDPH Facility ID Number: 0041723

Facility Name: Provena Our Lady of Victory

Address: 20 Briarcliff Lane Bourbonnais 60914
 Number City Zip Code

County: Kankakee

Telephone Number: (815) 937.2022 **Fax #** (815) 936.3231

IDPA ID Number: 371127787009

Date of Initial License for Current Owners: 11/6/81

Type of Ownership:

<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code <u>501 C3</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/05 to 12/31/05 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) <u>Michael R. Gordon</u>	
	(Title) <u>VP of Finance, CFO</u>	
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 Our Lady of Victory

0041723 Report Period Beginning: 01/01/05 Ending: 12/31/05

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 01/01/05

	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>107</u>	Skilled (SNF)	<u>107</u>	<u>39,055</u>	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	<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				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>24,654</u>	<u>2,733</u>	<u>5,776</u>	<u>33,163</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>24,654</u>	<u>2,733</u>	<u>5,776</u>	<u>33,163</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.91%

D. How many bed-hold days during this year were paid by the Department? 25 (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

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 11/16/1981

J. Was the facility purchased or leased after January 1, 1978?

YES Date 11/16/1981 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 28 and days of care provided 5,776

Medicare Intermediary Administar Federal

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/05 Fiscal Year: 12/31/05

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

Facility Name & ID Number Provena Our Lady of Victory # 0041723 Report Period Beginning: 01/01/05 Ending: 12/31/05

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	190,076	28,671	17,766	236,513		236,513		236,513			1
2	Food Purchase		142,118		142,118		142,118	1,317	143,435			2
3	Housekeeping	128,474	16,108	311	144,893		144,893		144,893			3
4	Laundry	19,960	9,855		29,815		29,815		29,815			4
5	Heat and Other Utilities			114,900	114,900		114,900	731	115,631			5
6	Maintenance	59,300	7,604	29,547	96,451		96,451	29,738	126,189			6
7	Other (specify):* Pastoral Care	31,637	44	33,067	64,748		64,748	(30,067)	34,681			7
8	TOTAL General Services	429,447	204,400	195,591	829,438		829,438	1,719	831,157			8
	B. Health Care and Programs											
9	Medical Director			8,961	8,961		8,961		8,961			9
10	Nursing and Medical Records	1,673,711	107,750	189,611	1,971,072		1,971,072		1,971,072			10
10a	Therapy			328,552	328,552		328,552		328,552			10a
11	Activities	58,945	1,212	5,874	66,031		66,031	802	66,833			11
12	Social Services	25,899	20	822	26,741		26,741		26,741			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,758,555	108,982	533,820	2,401,357		2,401,357	802	2,402,159			16
	C. General Administration											
17	Administrative	209,103	8,210	375,600	592,913		592,913	(164,818)	428,095			17
18	Directors Fees											18
19	Professional Services			15,234	15,234		15,234	163,698	178,932			19
20	Dues, Fees, Subscriptions & Promotions			34,927	34,927		34,927	(4,605)	30,322			20
21	Clerical & General Office Expenses			72,489	72,489		72,489	(4,838)	67,651			21
22	Employee Benefits & Payroll Taxes			488,785	488,785		488,785	73,096	561,881			22
23	Inservice Training & Education			4,627	4,627		4,627	2,455	7,082			23
24	Travel and Seminar			5,436	5,436		5,436	2,742	8,178			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			68,170	68,170		68,170	2,946	71,116			26
27	Other (specify):* Bad Debt			168,174	168,174		168,174	(168,174)				27
28	TOTAL General Administration	209,103	8,210	1,233,442	1,450,755		1,450,755	(97,498)	1,353,257			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,397,105	321,592	1,962,853	4,681,550		4,681,550	(94,977)	4,586,573			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: 01/01/05 Ending: 12/31/05

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 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			248,167	248,167	248,167	58,488	306,655				30
31	Amortization of Pre-Op. & Org.											31
32	Interest						82,273	82,273				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			624	624	624	7,356	7,980				34
35	Rent-Equipment & Vehicles			4,705	4,705	4,705	390	5,095				35
36	Other (specify):*											36
37	TOTAL Ownership			253,496	253,496	253,496	148,507	402,003				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			335,888	335,888	335,888		335,888				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			58,743	58,743	58,743		58,743				42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			394,631	394,631	394,631		394,631				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,397,105	321,592	2,610,980	5,329,677	5,329,677	53,530	5,383,207				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 Our Lady of Victory

0041723

Report Period Beginning:

01/01/05

Ending:

12/31/05

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				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	6,659	30		9
10	Interest and Other Investment Income	(2,924)	32		10
11	Discounts, Allowances, Rebates & Refunds	(10,651)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(168,174)	27		24
25	Fund Raising, Advertising and Promotional	(8,987)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (184,077)		\$	30

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)	267,674		34
35	Other- Attach Schedule	(30,067)		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 237,607		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 53,530		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.		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	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

OHF USE ONLY					
48		49		50	
				51	
					52

Provena Our Lady of Victory

ID# 0041723

Report Period Beginning: 01/01/05

Ending: 12/31/05

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Development - Misc	\$ (30,067)	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	(30,067)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Provena Our Lady of Victory

0041723

Report Period Beginning:

01/01/05

Ending:

12/31/05

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	1,317	0	0	0	0	0	0	0	0	0	1,317	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	731	0	0	0	0	0	0	0	0	0	731	5
6	Maintenance	0	257	29,481	0	0	0	0	0	0	0	0	29,738	6
7	Other (specify):*	(30,067)	0	0	0	0	0	0	0	0	0	0	(30,067)	7
8	TOTAL General Services	(30,067)	2,305	29,481	0	1,719	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	802	0	0	0	0	0	0	0	0	0	802	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	802	0	0	0	0	0	0	0	0	0	802	16
	C. General Administration													
17	Administrative	0	(147,682)	(17,136)	0	0	0	0	0	0	0	0	(164,818)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	14,708	148,990	0	0	0	0	0	0	0	0	163,698	19
20	Fees, Subscriptions & Promotions	(8,987)	4,382	0	0	0	0	0	0	0	0	0	(4,605)	20
21	Clerical & General Office Expenses	(10,651)	5,813	0	0	0	0	0	0	0	0	0	(4,838)	21
22	Employee Benefits & Payroll Taxes	0	23,563	49,533	0	0	0	0	0	0	0	0	73,096	22
23	Inservice Training & Education	0	2,455	0	0	0	0	0	0	0	0	0	2,455	23
24	Travel and Seminar	0	2,742	0	0	0	0	0	0	0	0	0	2,742	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	2,946	0	0	0	0	0	0	0	0	0	2,946	26
27	Other (specify):*	(168,174)	0	0	0	0	0	0	0	0	0	0	(168,174)	27
28	TOTAL General Administration	(187,812)	(91,073)	181,387	0	(97,498)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(217,879)	(87,966)	210,868	0	(94,977)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Provena Our Lady of Victory

0041723

Report Period Beginning:

01/01/05 Ending:

12/31/05

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	6,659	0	51,829	0	0	0	0	0	0	0	0	58,488	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,924)	0	85,197	0	0	0	0	0	0	0	0	82,273	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	7,356	0	0	0	0	0	0	0	0	7,356	34
35	Rent-Equipment & Vehicles	0	0	390	0	0	0	0	0	0	0	0	390	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	3,735	0	144,772	0	148,507	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	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(214,144)	(87,966)	355,640	0	53,530	45							

Facility Name & ID Number Provena Our Lady of Victory

0041723

Report Period Beginning:

01/01/05

Ending:

12/31/05

VII. RELATED PARTIES

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

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. 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)
1	V	2 Food	\$	Provena Senior Services	100.00%	\$ 1,317	\$ 1,317
2	V	5 Utilities		Provena Senior Services	100.00%	731	731
3	V	6 Maintenance - Other		Provena Senior Services	100.00%	257	257
4	V	11 Activities-Special Events		Provena Senior Services	100.00%	802	802
5	V	17 Admin - Misc. Other	240,000	Provena Senior Services	100.00%	6,871	(233,129)
6	V	17 Administrative Salaries		Provena Senior Services	100.00%	85,447	85,447
7	V	19 Professional Services		Provena Senior Services	100.00%	14,708	14,708
8	V	20 Dues,Subscriptions		Provena Senior Services	100.00%	4,382	4,382
9	V	21 Clerical Supplies		Provena Senior Services	100.00%	5,813	5,813
10	V	22 Employee Benefits		Provena Senior Services	100.00%	23,563	23,563
11	V	23 Education/Conference		Provena Senior Services	100.00%	2,455	2,455
12	V	24 Travel		Provena Senior Services	100.00%	2,742	2,742
13	V	26 Insurance		Provena Senior Services	100.00%	2,946	2,946
14	Total		\$ 240,000			\$ 152,034	\$ * (87,966)

* 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: 01/01/05 Ending: 12/31/05

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	30 Depreciation	\$	Provena Senior Services	100.00%	\$ 1,397	\$ 1,397	15
16	V	32 Interest		Provena Senior Services	100.00%	85,197	85,197	16
17	V	34 Rent - Facility		Provena Senior Services	100.00%	7,356	7,356	17
18	V	35 Rent - Equipment		Provena Senior Services	100.00%	390	390	18
19	V	17 Admin Salaries	80,400	Provena Health Services	100.00%	52,868	(27,532)	19
20	V	22 Employee Benefits		Provena Health Services	100.00%	22,106	22,106	20
21	V	30 Depreciation		Provena Health Services	100.00%	50,432	50,432	21
22	V	19 Admin Consulting,Other		Provena Health Services	100.00%	148,990	148,990	22
23	V	17 Information Systems Salaries	55,200	Provena Health Services	100.00%	11,925	(43,275)	23
24	V	22 Information Systems Benefits		Provena Health Services	100.00%	4,986	4,986	24
25	V	6 Information Systems - Equip Maint		Provena Health Services	100.00%	5,320	5,320	25
26	V	17 Admin Salaries		Provena Health Services	100.00%	32,995	32,995	26
27	V	22 Employee Benefits		Provena Health Services	100.00%	13,796	13,796	27
28	V	17 Information Systems Salaries		Provena Health Services	100.00%	20,676	20,676	28
29	V	22 Information Systems Benefits		Provena Health Services	100.00%	8,645	8,645	29
30	V	6 Information Systems - Equip Maint		Provena Health Services	100.00%	24,161	24,161	30
31	V	39 Ancillary Services - Other	335,888	Provena Senior Services Pharmacy	100.00%	335,888		31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 471,488			\$ 827,128	\$ * 355,640	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: 01/01/05 Ending: 12/31/05

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									\$		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: 01/01/05

Ending: 12/31/05

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

Name of Related Organization Provena Senior Services
 Street Address 19065 Hickory Creek Drive, Ste 310
 City / State / Zip Code Mokena, IL60448
 Phone Number (708)478-7900
 Fax Number (708)478-5387

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

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	2	Food	Management Fee Income 5,261,654	20	\$ 28,878	\$	240,000	\$ 1,317	1
2	5	Utilities	Management Fee Income 5,261,654	20	16,037		240,000	731	2
3	6	Maintenance - Other	Management Fee Income 5,261,654	20	5,629		240,000	257	3
4	11	Activities-Special Events	Management Fee Income 5,261,654	20	17,583		240,000	802	4
5	17	Admin - Misc. Other	Management Fee Income 5,261,654	20	150,633		240,000	6,871	5
6	17	Administrative Salaries	Management Fee Income 5,261,654	20	1,873,311	1,873,311	240,000	85,447	6
7	19	Professional Services	Management Fee Income 5,261,654	20	322,442		240,000	14,708	7
8	20	Dues,Subscriptions	Management Fee Income 5,261,654	20	96,069		240,000	4,382	8
9	21	Clerical Supplies	Management Fee Income 5,261,654	20	127,431		240,000	5,813	9
10	22	Employee Benefits	Management Fee Income 5,261,654	20	516,585		240,000	23,563	10
11	23	Education/Conference	Management Fee Income 5,261,654	20	53,828		240,000	2,455	11
12	24	Travel	Management Fee Income 5,261,654	20	60,116		240,000	2,742	12
13	26	Insurance	Management Fee Income 5,261,654	20	64,582		240,000	2,946	13
14	30	Depreciation	Management Fee Income 5,261,654	20	30,629		240,000	1,397	14
15	32	Interest	Management Fee Income 5,261,654	20	1,867,812		240,000	85,197	15
16	34	Rent - Facility	Management Fee Income 5,261,654	20	161,270		240,000	7,356	16
17	35	Rent - Equipment	Management Fee Income 5,261,654	20	8,543		240,000	390	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 5,401,378	\$ 1,873,311		\$ 246,374	25

Facility Name & ID Number Provena Our Lady of Victory

0041723

Report Period Beginning:

01/01/05

Ending: 12/31/05

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

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

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

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	17	Admin Salaries	Operating Expense	1,146,264	10	\$ 753,738	\$ 753,738	80,400	\$ 52,868	1
2	22	Employee Benefits	Operating Expense	1,146,264	10	315,161		80,400	22,106	2
3	30	Depreciation	Operating Expense	1,146,264	10	719,013		80,400	50,432	3
4	19	Admin Consulting,Other	Operating Expense	1,146,264	10	2,124,158		80,400	148,990	4
5	17	Information Systems Salaries	Operating Expense	791,616	10	171,021	171,021	55,200	11,925	5
6	22	Information Systems Benefits	Operating Expense	791,616	10	71,509		55,200	4,986	6
7	6	Information Systems - Equip Main	Operating Expense	791,616	10	76,287		55,200	5,320	7
8	17	Admin Salaries	Direct Cost	1,146,264	10	470,416	470,416	80,400	32,995	8
9	22	Employee Benefits	Direct Cost	1,146,264	10	196,696		80,400	13,796	9
10	17	Information Systems Salaries	Direct Cost	791,616	10	296,512	296,512	55,200	20,676	10
11	22	Information Systems Benefits	Direct Cost	791,616	10	123,981		55,200	8,645	11
12	6	Information Systems - Equip Main	Direct Cost	791,616	10	346,486		55,200	24,161	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					\$ 5,664,978	\$ 1,691,687		\$ 396,900	25

Facility Name & ID Number Provena Our Lady of Victory

0041723

Report Period Beginning: 01/01/05

Ending: 12/31/05

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	39	Ancillary Services - Other	Direct Allocation		\$	\$		\$ 335,888	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				\$	\$		\$ 335,888	25

Facility Name & ID Number Provena Our Lady of Victory # 0041723 Report Period Beginning: 01/01/05 Ending: 12/31/05

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	Provena Senior Services									82,273	10									
11											11									
12											12									
13											13									
14	TOTAL Non-Facility Related					\$	\$		\$	82,273	14									
15	TOTALS (line 9+line14)					\$	\$		\$	82,273	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.)

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 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 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 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 Bureau of Health Finance at (217) 782-1630.

2004 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 _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2004 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 2004.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</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 original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number Provena Our Lady of Victory

0041723 Report Period Beginning:

01/01/05 Ending:

12/31/05

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, CNA 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>	1
2	<u>Related Party</u>		<u>1985</u>	<u>3,003</u>	2
3	TOTALS			\$ 138,003	3

Facility Name & ID Number Provena Our Lady of Victory

0041723

Report Period Beginning:

01/01/05

Ending:

12/31/05

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR OHF 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	80			1981	\$ 507,112	\$ 20,284	25	\$ 20,284		\$ 490,200	4
5	8			1984	726,964	29,079	25	29,079		639,293	5
6	9			1987	63,355	1,496	20	1,496		60,463	6
7	10			1995	2,520,706	62,705	35	62,705		665,658	7
8											8
	Improvement Type**										
9	Various			1982	95,473	3,819	25	3,819		89,746	9
10	Various			1985	300		15			300	10
11	Various			1986	17,173	818	21	818		15,131	11
12	Various			1987	13,473	642	21	642		11,867	12
13	Various			1988	6,000		15			6,000	13
14	Various			1989	1,046		15			1,046	14
15	Various			1990	90,796	3,026	15	3,026		90,796	15
16	Various			1991	21,073		10			21,073	16
17	Various			1992	12,150	608	20	608		7,898	17
18	Various			1994	3,258		8			3,258	18
19	Various			1995	9,836	42	6	42		9,836	19
20	Various			1996	95,992	5,061	10	5,061		53,580	20
21	Various			1997	200,728	7,146	7	7,146		150,793	21
22	Various			1998	48,287	853	5	853		48,287	22
23	Various			1999	74,075	1,767	6	1,767		52,301	23
24	Various			2000	24,736	1,837	7	1,837		18,296	24
25	Various			2001	107,190	13,038	6	13,038		60,080	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, Line 70 for total

Facility Name & ID Number Provena Our Lady of Victory

0041723

Report Period Beginning:

01/01/05

Ending:

12/31/05

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	
37	DESC: PAINTING, PATCHING AND SANDI	2002	\$ 4,733	\$ 947	5	\$ 947	\$	\$ 3,313	37
38	DESC: 80 GAL HOT WATER HEATER	2002	2,301	230	10	230		805	38
39	DESC: ELECTRIC HEATING AND COLLOIN	2002	3,990	266	15	266		931	39
40	DESC: REPAIR BROKEN PIPE IN ATTIC	2002	119	12	10	12		36	40
41	DESC: REPAIR CONDUIT AND WIRES IN	2002	108	11	10	11		32	41
42	DESC: CARPET FOR A WING	2002	4,710	942	5	942		2,826	42
43	DESC: GARBAGE DISPOSAL	2002	616	123	5	123		431	43
44	DESC: IDPA LICENSING	2002	450	90	5	90		315	44
45	DESC: SPRINKLER SYSTEM PHASE TWO	2002	38,439	641	10	641		12,173	45
46	DESC: IDPA LICENSING	2002	4,631	926	5	926		3,242	46
47	DESC: A/C PACKAGE HEAT PUMP	2002			10			87	47
48	DESC: A/C PACKAGE HEAT PUMP	2002	865	87	10	87		260	48
49	DESC: LIFE SAFETY CODE CERTIFICATI	2002	11,545	1,649	7	1,649		4,948	49
50									50
51	DESC: OLV CONVERSION / ARCHITECTUR	2003	1,575	315	5	315		788	51
52	DESC: LIFE SAFETY CODE CERTIFICATI	2003	90	18	5	18		45	52
53	DESC: NINE NEW SMOKE DETECTORS	2003	5,734	573	10	573		1,434	53
54	DESC: CARPET FOR LOBBY	2003	1,063	213	5	213		532	54
55	DESC: CONSTRUCTION ADMINISTRATION-	2003	315	63	5	63		158	55
56	DESC: CEILING REPAIR	2003	2,041	204	10	204		510	56
57	DESC: REGRADE/RESOIL EMPLOYEE PARKING LOT	2003	7,197	120	10	120		1,919	57
58	DESC: FIRE PROTECTION SYSTEM	2003	79,026	7,903	10	7,903		15,805	58
59	DESC: SPRINKLER SYSTEM	2003	32,123	214	25	214		2,784	59
60	DESC: HEATING AND COOLING HVAC UNI	2003	42,000	2,800	15	2,800		5,600	60
61	DESC: ADDITIONAL SMOKE DETECTORS	2003	3,649	365	10	365		730	61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 4,887,045	\$ 170,930		\$ 170,930	\$	\$ 2,555,603	70

**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:

01/01/05

Ending:

12/31/05

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		\$ 4,887,045	\$ 170,930		\$ 170,930	\$	\$ 2,555,603	1
2	DESC: EMERGENCY GENERATOR	2004	5,363	1,073	5	1,073		1,609	2
3	DESC: DESIGN FOR SPRINKLER PROJECT	2004	90	5	20	5		7	3
4	DESC: SPRINKLER SYSTEM	2004	40,889	1,636	25	1,636		2,436	4
5	DESC: SPRINKLER	2004	2,126	85	25	85		128	5
6	DESC: AIR COMPRESSOR FOR SPRINKLER	2004	1,855	124	15	124		124	6
7	DESC: SPRINKLER SYSTEM PHASE 3 AND	2004	585	117	5	117		176	7
8	DESC: PAINTING WORK FOR SPRINKLER	2004	3,631	726	5	726		1,089	8
9	DESC: IDPH FINAL PUNCH LIST ITEMS	2004	1,538	103	15	103		154	9
10	DESC: SPRINKLER SYSTEM PHASE 3 AND	2004	135	27	5	27		41	10
11	DESC: B & F REVIEW FOR SPRINKLER	2004	462	92	5	92		139	11
12	DESC: CONSTRUCTION ADMIN - OLOV SP	2004	45	9	5	9		14	12
13	DESC: CARPET-ENTRANCE,LOBBY,C&D CO	2004	43,622	8,724	5	8,724		8,724	13
14	DESC: EXTERIOR PAINTING	2004	2,825	565	5	565		848	14
15	DESC: CONNECT BATHROOM EXHAUST FAN	2004	1,989	398	5	398		597	15
16	DESC: DESIGN FOR SPRINKLER SYSTEM	2004	90	18	5	18		27	16
17	DESC: COOLING UNIT FOR FRONT LOBBY	2004	12,900	1,290	10	1,290		1,935	17
18	DESC: 2 DRY SPRINKLERS IN ELECTRIC	2004	1,363	136	10	136		204	18
19	DESC: REMOVE / REPLACE EXHAUST FAN	2004	14,741	983	15	983		1,474	19
20	DESC: SPRINKLER PROJECT	2004	45	9	5	9		9	20
21	DESC: ELECTRICAL INSTALLATION FOR	2004	2,255	226	10	226		338	21
22	DESC: MOVED DRY PENDENT IN VESTIBU	2004	1,632	163	10	163		245	22
23	DESC: FLEXIBLE DUCT REPLACEMENT	2004	2,366	237	10	237		355	23
24	DESC: REMODEL BATHROOMS	2004	34,166	2,278	15	2,278		3,417	24
25	DESC: RELOCATE 2 PULL FIRE ALARMS,	2004	3,942	788	5	788		1,183	25
26	DESC: AWNING FOR TLC ENTRANCE	2004	4,300	287	15	287		430	26
27	DESC: BATHROOM RENOVATION	2004	80,548	5,370	15	5,370		8,055	27
28	DESC: VINYL GRAPHICS TO 2 AWNINGS	2004	380	38	10	38		57	28
29	DESC: GENERATOR INSPECTION & REPAI	2004	1,534	307	5	307		460	29
30	DESC: INSTALL THREE APMPERAGE ON G	2004	740	106	7	106		106	30
31	DESC: INSTALL A/C IN ACTIVITY ROOM	2004	11,500	1,150	10	1,150		1,150	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,164,702	\$ 197,997		\$ 197,997	\$	\$ 2,591,130	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:

01/01/05

Ending:

12/31/05

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		\$ 5,164,702	\$ 197,997		\$ 197,997	\$	\$ 2,591,130	1
2	DESC: (2) STEELCRAFT WINDOWS	2005	761	76	5	152	76	152	2
3	DESC: (6) 120V RECEPTICLES FOR THE	2005	2,600	130	10	260	130	260	3
4	DESC: CONNECT 2 FURNACES TO EMERGE	2005	7,952	398	10	795	398	795	4
5	DESC: REPAVING OF PARKING LOT	2005	10,996	229	8	1,375	1,145	1,375	5
6	DESC: ASPHALT IN PARKING LOT	2005	9,576	199	8	1,197	997	1,197	6
7	DESC: INSTALLATION OF EMERGENCY GE	2005	6,996	700	5	1,399	700	1,399	7
8	DESC: MOVE SIGN TO CORNER	2005	1,500	150	5	300	150	300	8
9	DESC: TREE & STUMP REMOVAL	2005	1,500	150	5	300	150	300	9
10	DESC: STEELCRAFT ENTRANCE PAK	2005	2,215	111	10	222	111	222	10
11	DESC: PHONE SYSTEM EXPANSION	2005	991	33	15	66	33	66	11
12	DESC: SIGN ON CORNER AND RELOCATE	2005	1,972	99	10	197	99	197	12
13	DESC: LANDSCAPING	2005	13,000	650	10	1,300	650	1,300	13
14	DESC: KM SYSTEMS 2100 & 3100 SERIE	2005	8,119	406	10	812	406	812	14
15	DESC: ELECTRICAL - 110 V WIRING FO	2005	2,841	71	20	142	71	142	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)		\$ 5,235,722	\$ 201,398		\$ 206,514	\$ 5,116	\$ 2,599,647	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: 01/01/05 Ending: 12/31/05

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	\$ 253,592	\$ 39,553	\$ 39,553	\$	8	\$ 115,984	71
72	Current Year Purchases	28,758	1,602	3,145	1,543	8	3,145	72
73	Fully Depreciated Assets	259,925					259,925	73
74	Home office allocation		51,829	51,829				74
75	TOTALS	\$ 542,275	\$ 92,984	\$ 94,527	\$ 1,543		\$ 379,055	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	1999	\$ 44,910	\$ 5,614	\$ 5,614	\$	8	\$ 36,489	76
77										77
78										78
79										79
80	TOTALS			\$ 44,910	\$ 5,614	\$ 5,614	\$		\$ 36,489	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)		\$ 5,960,909	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 299,996	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 306,655	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$ 6,659	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 3,015,191	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: _____

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:				\$ 624			3
4	Additions							4
5	Allocation Home Office				7,356			5
6								6
7	TOTAL				\$ 7,980			7

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.	_____ /2006	\$ _____
13.	_____ /2007	\$ _____
14.	_____ /2008	\$ _____

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: \$ 30,249 Description: Nursing - \$25,154.71, Admin - \$4,704.50, home office - \$390

(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	N/A		\$ _____	\$ _____	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 Our Lady of Victory # 0041723 Report Period Beginning: 01/01/05 Ending: 12/31/05

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.)

<p>1. HAVE YOU TRAINED CNAs 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 CNA _____</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 CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		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 Our Lady of Victory# 0041723

Report Period Beginning:

01/01/05

Ending:

12/31/05

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	10a,3	hrs	\$	2,295	\$ 119,817	\$	2,295	\$ 119,817	1
2	Licensed Speech and Language Development Therapist	10a,3	hrs		1,431	74,705		1,431	74,705	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a,3	hrs		2,568	134,030		2,568	134,030	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				335,888		335,888	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$	6,294	\$ 328,552	\$ 335,888	6,294	\$ 664,440	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.

Facility Name & ID Number Provena Our Lady of Victory# 0041723Report Period Beginning: 01/01/05

Ending:

12/31/05

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/05

(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	\$ 10,947,364	\$	1
2	Cash-Patient Deposits	102,762		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	8,022,174		3
4	Supply Inventory (priced at)	562,029		4
5	Short-Term Investments			5
6	Prepaid Insurance	53,455		6
7	Other Prepaid Expenses	234,588		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 19,922,372	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	8,323,187		12
13	Land	6,872,845		13
14	Buildings, at Historical Cost	79,429,531		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	15,136,519		16
17	Accumulated Depreciation (book methods)	(44,514,067)		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): <u>Goodwill</u>	133,848		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 65,381,863	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 85,304,235	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 3,028,501	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	2,196,854		28
29	Short-Term Notes Payable	35,066		29
30	Accrued Salaries Payable	2,281,363		30
31	Accrued Taxes Payable (excluding real estate taxes)	52,968		31
32	Accrued Real Estate Taxes(Sch.IX-B)	222,071		32
33	Accrued Interest Payable	26,274		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Due to Related Party</u>	542,408		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 8,385,505	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,329,784		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	219,687		42
	Other Long-Term Liabilities(specify):			
43	<u>Conditional Asset Retirement</u>	616,044		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,165,515	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 10,551,020	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 74,753,215	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 85,304,235	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 72,625,309	1
2	Restatements (describe):		2
3	FAS47 Change in accounting principal	(271,871)	3
4	Adj. To Reconcile Consolidated Equity and Consolidated	2,575,765	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 74,929,203	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(205,635)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised	(40,261)	10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes	240,328	12
13	Dividends Paid or Other Distributions to Owners	(170,420)	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)	\$ (175,988)	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 74,753,215	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Provena Our Lady of Victory# 0041723Report Period Beginning: 01/01/05Ending: 12/31/05**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	\$ 4,028,711	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,028,711	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	939,536	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 939,536	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		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)	\$	23
D. Non-Operating Revenue			
24	Contributions	64,963	24
25	Interest and Other Investment Income***	2,924	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 67,887	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Purchase Rebates</u>	81,421	28
28a	<u>Misc. Income</u>	6,487	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 87,908	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,124,042	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	829,438	31
32	Health Care	2,401,357	32
33	General Administration	1,450,755	33
B. Capital Expense			
34	Ownership	253,496	34
C. Ancillary Expense			
35	Special Cost Centers	335,888	35
36	Provider Participation Fee	58,743	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,329,677	40
41	Income before Income Taxes (line 30 minus line 40)**	(205,635)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (205,635)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes 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: 01/01/05

Ending: 12/31/05

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	984	1,064	\$ 32,544	\$ 30.59	1
2	Assistant Director of Nursing	1,912	2,080	52,516	25.25	2
3	Registered Nurses	13,012	14,191	338,332	23.84	3
4	Licensed Practical Nurses	28,226	30,241	551,988	18.25	4
5	CNAs & Orderlies	60,131	63,659	669,673	10.52	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,113	2,306	28,658	12.43	8
9	Activity Director	1,920	2,080	30,251	14.54	9
10	Activity Assistants	2,630	3,384	28,694	8.48	10
11	Social Service Workers	1,944	2,080	25,899	12.45	11
12	Dietician	1,684	1,773	34,611	19.52	12
13	Food Service Supervisor	412	485	5,492	11.32	13
14	Head Cook	1,638	1,760	20,841	11.84	14
15	Cook Helpers/Assistants	16,597	17,674	129,132	7.31	15
16	Dishwashers					16
17	Maintenance Workers	3,731	4,060	59,300	14.61	17
18	Housekeepers	14,722	16,063	128,474	8.00	18
19	Laundry	1,992	2,136	19,960	9.34	19
20	Administrator	1,948	2,071	80,622	38.93	20
21	Assistant Administrator					21
22	Other Administrative	4,915	5,203	80,331	15.44	22
23	Office Manager					23
24	Clerical	5,662	6,077	48,150	7.92	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) <u>Pastoral Care</u>	1,883	2,080	31,637	15.21	33
34	TOTAL (lines 1 - 33)	168,056	180,467	\$ 2,397,105 *	\$ 13.28	34

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

** See instructions.

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	312	\$ 16,227	1,3	35
36	Medical Director	\$600/mth	7,200	9,3	36
37	Medical Records Consultant	29	1,648	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	3	148	11,3	44
45	Social Service Consultant	18	1,062	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	362	\$ 26,285		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	512	\$ 24,434	10,3	50
51	Licensed Practical Nurses	2,329	84,721	10,3	51
52	Certified Nurse Assistants/Aides	1,636	36,672	10,3	52
53	TOTAL (lines 50 - 52)	4,477	\$ 145,827		53

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. 5048 - Life Service Network
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? Yes If YES, what is the capacity? 107
- (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. \$ 38,924 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. \$ 58,743
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? N/A Indicate the amount. \$ N/A
- (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 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. Not issued yet
- (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? Yes
Attach invoices and a summary of services for all architect and appraisal fees.