

		FOR BHF USE					

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**2006**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2006)**

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

**HFS 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
<b>IRS Exemption Code</b> <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 01/01/06 to 12/31/06 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.

<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) _____
	(Type or Print Name) <u>Michael R. Gordon</u>	
	(Title) <u>VP of Finance, CFO</u>	
<b>Paid Preparer</b>	(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: 01/01/06 Ending: 12/31/06

## 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 07/01/06

	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>24,703</u>	<u>2,139</u>	<u>7,089</u>	<u>33,931</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>24,703</u>	<u>2,139</u>	<u>7,089</u>	<u>33,931</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.88%

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

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

N/A - NoneF. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 &amp; 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 55 and days of care provided 7,012Medicare Intermediary Administar Federal

## IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\* Is your fiscal year identical to your tax year? YES  NO Tax Year: 12/31/06 Fiscal Year: 12/31/06

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

Facility Name & ID Number Provena Our Lady of Victory # 0041723 Report Period Beginning: 01/01/06 Ending: 12/31/06

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
	<b>A. General Services</b>										
1	Dietary	207,671	25,761	11,646	245,078		245,078		245,078		1
2	Food Purchase		147,812		147,812		147,812	1,578	149,390		2
3	Housekeeping	132,226	15,071	116	147,413		147,413		147,413		3
4	Laundry	20,534	7,229		27,763		27,763		27,763		4
5	Heat and Other Utilities			106,915	106,915		106,915	544	107,459		5
6	Maintenance	56,675	10,208	31,531	98,414		98,414	30,051	128,465		6
7	Other (specify):*	32,843	588	30,132	63,563		63,563	(29,555)	34,008		7
8	<b>TOTAL General Services</b>	<b>449,949</b>	<b>206,669</b>	<b>180,340</b>	<b>836,958</b>		<b>836,958</b>	<b>2,618</b>	<b>839,576</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			7,967	7,967		7,967		7,967		9
10	Nursing and Medical Records	1,753,192	119,384	451,852	2,324,428		2,324,428		2,324,428		10
10a	Therapy			443,785	443,785		443,785		443,785		10a
11	Activities	58,034	1,718	9,560	69,312		69,312	627	69,939		11
12	Social Services	26,912		1,214	28,126		28,126		28,126		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>1,838,138</b>	<b>121,102</b>	<b>914,378</b>	<b>2,873,618</b>		<b>2,873,618</b>	<b>627</b>	<b>2,874,245</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	281,539	8,310	419,880	709,729		709,729	(202,518)	507,211		17
18	Directors Fees										18
19	Professional Services			11,755	11,755		11,755	183,825	195,580		19
20	Dues, Fees, Subscriptions & Promotions			40,270	40,270		40,270	(1,694)	38,576		20
21	Clerical & General Office Expenses			24,327	24,327		24,327	(162,837)	(138,510)		21
22	Employee Benefits & Payroll Taxes			449,431	449,431		449,431	72,376	521,807		22
23	Inservice Training & Education			5,528	5,528		5,528	1,895	7,423		23
24	Travel and Seminar			6,764	6,764		6,764	2,851	9,615		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			85,220	85,220		85,220	70	85,290		26
27	Other (specify):* <b>Bad Debt</b>			191,008	191,008		191,008	(191,008)			27
28	<b>TOTAL General Administration</b>	<b>281,539</b>	<b>8,310</b>	<b>1,234,183</b>	<b>1,524,032</b>		<b>1,524,032</b>	<b>(297,040)</b>	<b>1,226,992</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>2,569,626</b>	<b>336,081</b>	<b>2,328,901</b>	<b>5,234,608</b>		<b>5,234,608</b>	<b>(293,795)</b>	<b>4,940,813</b>		<b>29</b>

\*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: 01/01/06 Ending: 12/31/06

## 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	
	<b>D. Ownership</b>											
30	Depreciation			248,170	248,170		248,170	68,732	316,902			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							89,651	89,651			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			624	624		624	6,860	7,484			34
35	Rent-Equipment & Vehicles			6,845	6,845		6,845	617	7,462			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			255,639	255,639		255,639	165,860	421,499			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			370,351	370,351		370,351		370,351			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):*											43
44	<b>TOTAL Special Cost Centers</b>			428,934	428,934		428,934		428,934			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,569,626	336,081	3,013,474	5,919,181		5,919,181	(127,935)	5,791,246			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: 01/01/06

Ending: 12/31/06

**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	10,098	30		9
10	Interest and Other Investment Income	(541)	32		10
11	Discounts, Allowances, Rebates & Refunds	(167,399)	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	(191,008)	27		24
25	Fund Raising, Advertising and Promotional	(5,336)	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	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (354,186)		\$	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)	255,806		34
35	Other- Attach Schedule	(29,555)		35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 226,251		36
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ (127,935)		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		X			45
46	Other-Attach Schedule		X			46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY					
48		49		50	51
					52

Provena Our Lady of Victory

ID# 0041723

Report Period Beginning: 01/01/06

Ending: 12/31/06

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Development Office Supplies	\$ (423)	7	1
2	Development Misc.	(28,884)	7	2
3	Development Travel	(248)	7	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	<b>Total</b>	(29,555)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Provena Our Lady of Victory# 0041723

Report Period Beginning:

01/01/06

Ending:

12/31/06**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)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	1,578	0	0	0	0	0	0	0	0	0	1,578	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	544	0	0	0	0	0	0	0	0	0	544	5
6	Maintenance	0	108	29,943	0	0	0	0	0	0	0	0	30,051	6
7	Other (specify):*	(29,555)	0	0	0	0	0	0	0	0	0	0	(29,555)	7
8	<b>TOTAL General Services</b>	<b>(29,555)</b>	<b>2,230</b>	<b>29,943</b>	<b>0</b>	<b>2,618</b>	<b>8</b>							
	<b>B. Health Care and Programs</b>													
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	627	0	0	0	0	0	0	0	0	0	627	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	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>627</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>627</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	(153,358)	(49,160)	0	0	0	0	0	0	0	0	(202,518)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	14,761	169,064	0	0	0	0	0	0	0	0	183,825	19
20	Fees, Subscriptions & Promotions	(5,336)	3,642	0	0	0	0	0	0	0	0	0	(1,694)	20
21	Clerical & General Office Expenses	(167,399)	4,562	0	0	0	0	0	0	0	0	0	(162,837)	21
22	Employee Benefits & Payroll Taxes	0	23,686	48,690	0	0	0	0	0	0	0	0	72,376	22
23	Inservice Training & Education	0	1,895	0	0	0	0	0	0	0	0	0	1,895	23
24	Travel and Seminar	0	2,851	0	0	0	0	0	0	0	0	0	2,851	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	70	0	0	0	0	0	0	0	0	0	70	26
27	Other (specify):*	(191,008)	0	0	0	0	0	0	0	0	0	0	(191,008)	27
28	<b>TOTAL General Administration</b>	<b>(363,743)</b>	<b>(101,891)</b>	<b>168,594</b>	<b>0</b>	<b>(297,040)</b>	<b>28</b>							
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(393,298)</b>	<b>(99,034)</b>	<b>198,537</b>	<b>0</b>	<b>(293,795)</b>	<b>29</b>							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Provena Our Lady of Victory

# 0041723

Report Period Beginning:

01/01/06 Ending:

12/31/06

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	10,098	0	58,634	0	0	0	0	0	0	0	0	68,732	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(541)	0	90,192	0	0	0	0	0	0	0	0	89,651	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	6,860	0	0	0	0	0	0	0	0	6,860	34
35	Rent-Equipment & Vehicles	0	0	617	0	0	0	0	0	0	0	0	617	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>9,557</b>	<b>0</b>	<b>156,303</b>	<b>0</b>	<b>165,860</b>	<b>37</b>							
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(383,741)</b>	<b>(99,034)</b>	<b>354,840</b>	<b>0</b>	<b>(127,935)</b>	<b>45</b>							

Facility Name & ID Number Provena Our Lady of Victory

# 0041723

Report Period Beginning:

01/01/06

Ending:

12/31/06

**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%	\$ 1,578	\$ 1,578
2	V	5 Utilities		Provena Senior Services	100.00%	544	544
3	V	6 Maintenance - Other		Provena Senior Services	100.00%	108	108
4	V	11 Activities-Special Events		Provena Senior Services	100.00%	627	627
5	V	17 Admin - Misc. Other	246,000	Provena Senior Services	100.00%	5,135	(240,865)
6	V	17 Administrative Services		Provena Senior Services	100.00%	87,507	87,507
7	V	19 Professional Salaries		Provena Senior Services	100.00%	14,761	14,761
8	V	20 Dues,Subscriptions		Provena Senior Services	100.00%	3,642	3,642
9	V	21 Clerical Supplies		Provena Senior Services	100.00%	4,562	4,562
10	V	22 Employee Benefits		Provena Senior Services	100.00%	23,686	23,686
11	V	23 Education/Conference		Provena Senior Services	100.00%	1,895	1,895
12	V	24 Travel		Provena Senior Services	100.00%	2,851	2,851
13	V	26 Insurance		Provena Senior Services	100.00%	70	70
14	Total		\$ 246,000			\$ 146,966	\$ * (99,034)

\* 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: 01/01/06 Ending: 12/31/06

## 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 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
		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%	\$ 1,407	\$ 1,407	15
16	V	32	Interest		Provena Senior Services	100.00%	90,192	90,192	16
17	V	34	Rent - Facility		Provena Senior Services	100.00%	6,860	6,860	17
18	V	35	Rent - Equipment		Provena Senior Services	100.00%	617	617	18
19	V	17	Admin Salaries	83,160	Provena Health Services	100.00%	52,698	(30,462)	19
20	V	22	Employee Benefits		Provena Health Services	100.00%	20,573	20,573	20
21	V	30	Depreciation		Provena Health Services	100.00%	57,227	57,227	21
22	V	19	Admin Consulting,Other		Provena Health Services	100.00%	169,064	169,064	22
23	V	17	Information Systems Salaries	90,720	Provena Health Services	100.00%	12,780	(77,940)	23
24	V	22	Information Systems Benefits		Provena Health Services	100.00%	4,989	4,989	24
25	V	6	Information Systems - Equip Maint		Provena Health Services	100.00%	8,239	8,239	25
26	V	17	Admin Salaries		Provena Health Services	100.00%	35,423	35,423	26
27	V	22	Employee Benefits		Provena Health Services	100.00%	13,829	13,829	27
28	V	17	Information Systems Salaries		Provena Health Services	100.00%	23,819	23,819	28
29	V	22	Information Systems Benefits		Provena Health Services	100.00%	9,299	9,299	29
30	V	6	Information Systems - Equip Maint		Provena Health Services	100.00%	21,704	21,704	30
31	V	39	Ancillary Services - Other	370,351	Provena Senior Services Pharmacy	100.00%	370,351		31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 544,231				\$ 899,071	\$ * 354,840	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: 01/01/06 Ending: 12/31/06

## 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:

01/01/06

Ending: 12/31/06

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 5,596,693	20	\$ 35,910	\$	246,000	\$ 1,578	1
2	5	Utilities	Management Fee Income 5,596,693	20	12,383		246,000	544	2
3	6	Maintenance - Other	Management Fee Income 5,596,693	20	2,446		246,000	108	3
4	11	Activities-Special Events	Management Fee Income 5,596,693	20	14,275		246,000	627	4
5	17	Admin - Misc. Other	Management Fee Income 5,596,693	20	116,818		246,000	5,135	5
6	17	Administrative Salaries	Management Fee Income 5,596,693	20	1,990,843	1,990,843	246,000	87,507	6
7	19	Professional Services	Management Fee Income 5,596,693	20	335,820		246,000	14,761	7
8	20	Dues,Subscriptions	Management Fee Income 5,596,693	20	82,869		246,000	3,642	8
9	21	Clerical Supplies	Management Fee Income 5,596,693	20	103,786		246,000	4,562	9
10	22	Employee Benefits	Management Fee Income 5,596,693	20	538,870		246,000	23,686	10
11	23	Education/Conference	Management Fee Income 5,596,693	20	43,116		246,000	1,895	11
12	24	Travel	Management Fee Income 5,596,693	20	64,864		246,000	2,851	12
13	26	Insurance	Management Fee Income 5,596,693	20	1,591		246,000	70	13
14	30	Depreciation	Management Fee Income 5,596,693	20	32,015		246,000	1,407	14
15	32	Interest	Management Fee Income 5,596,693	20	2,051,940		246,000	90,192	15
16	34	Rent - Facility	Management Fee Income 5,596,693	20	156,067		246,000	6,860	16
17	35	Rent - Equipment	Management Fee Income 5,596,693	20	14,036		246,000	617	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 5,597,649	\$ 1,990,843		\$ 246,042	25

Facility Name & ID Number Provena Our Lady of Victory

# 0041723

Report Period Beginning:

01/01/06

Ending: 12/31/06

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 Services  
 Street Address 9223 West St. Francis Road  
 City / State / Zip Code Frankfort, IL 60423  
 Phone Number ( 815)469-4888  
 Fax Number ( 815)469-4864

1	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	1,192,116	10	\$ 755,436	\$ 755,436	83,160	\$ 52,698	1
2	22	Employee Benefits	Operating Expense	1,192,116	10	294,918		83,160	20,573	2
3	30	Depreciation	Operating Expense	1,192,116	10	820,363		83,160	57,227	3
4	19	Admin Consulting,Other	Operating Expense	1,192,116	10	2,423,574		83,160	169,064	4
5	17	Information Systems Salaries	Operating Expense	1,301,820	10	183,390	183,390	90,720	12,780	5
6	22	Information Systems Benefits	Operating Expense	1,301,820	10	71,595		90,720	4,989	6
7	6	Information Systems - Equip Main	Operating Expense	1,301,820	10	118,233		90,720	8,239	7
8	17	Admin Salaries	Direct Cost	1,192,116	10	507,799	507,799	83,160	35,423	8
9	22	Employee Benefits	Direct Cost	1,192,116	10	198,242		83,160	13,829	9
10	17	Information Systems Salaries	Direct Cost	1,301,820	10	341,798	341,798	90,720	23,819	10
11	22	Information Systems Benefits	Direct Cost	1,301,820	10	133,436		90,720	9,299	11
12	6	Information Systems - Equip Main	Direct Cost	1,301,820	10	311,444		90,720	21,704	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					\$ 6,160,228	\$ 1,788,423		\$ 429,644	25

Facility Name & ID Number Provena Our Lady of Victory

# 0041723

Report Period Beginning:

01/01/06

Ending: 12/31/06

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		\$	\$		\$ 370,351	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				\$	\$		\$ 370,351	25

**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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1										1										
2										2										
3										3										
4										4										
5										5										
<b>Working Capital</b>																				
6										6										
7										7										
8										8										
9	<b>TOTAL Facility Related</b>					\$	\$		\$	9										
<b>B. Non-Facility Related*</b>																				
10	<b>Provena Senior Services</b>									<b>89,651</b>	10									
11										11										
12										12										
13										13										
14	<b>TOTAL Non-Facility Related</b>					\$	\$		\$	<b>89,651</b>	14									
15	<b>TOTALS (line 9+line14)</b>					\$	\$		\$	<b>89,651</b>	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:** 2005 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 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2006 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.

**2005 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 2005 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 2005.

(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. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ _____	\$ _____

**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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

**PLEASE NOTE:** Payment information from the Internet or otherwise is not considered acceptable tax bill documentation. Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number Provena Our Lady of Victory

# 0041723 Report Period Beginning:

01/01/06 Ending:

12/31/06

**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).

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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	<b>TOTALS</b>			\$ <b>138,003</b>	3

Facility Name & ID Number Provena Our Lady of Victory

# 0041723

Report Period Beginning:

01/01/06

Ending:

12/31/06

**XI. OWNERSHIP COSTS (continued)**

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	80			1981	\$ 507,112	\$ 20,284	25	\$ 20,284		\$ 490,200	4
5	8			1984	726,964	29,079	25	29,079		668,372	5
6	9			1987	63,355	1,496	20	1,496		63,246	6
7	10			1995	2,520,706	64,282	35	64,282		729,624	7
8											8
	<b>Improvement Type**</b>										
9	Various			1982	95,473	3,819	25	3,819		93,565	9
10	Various			1985	300		15			300	10
11	Various			1986	17,173	818	21	818		15,949	11
12	Various			1987	13,473	642	21	642		12,509	12
13	Various			1988	6,000		15			6,000	13
14	Various			1989	1,046		15			1,046	14
15	Various			1990	90,796		15			90,796	15
16	Various			1991	21,073		10			21,073	16
17	Various			1992	12,150	608	20	608		8,505	17
18	Various			1994	3,258		8			3,258	18
19	Various			1995	9,836		6			9,836	19
20	Various			1996	95,992	4,919	10	4,919		58,458	20
21	Various			1997	200,728	7,769	7	7,769		159,437	21
22	Various			1998	48,287		5			48,287	22
23	Various			1999	74,075	3,376	6	3,376		55,316	23
24	Various			2000	24,736	1,583	7	1,583		19,741	24
25	Various			2001	107,190	10,396	6	10,396		70,476	25
26	Various			2002	72,508	9,127	8	9,127		37,875	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:

01/01/06

Ending:

12/31/06

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: OLV CONVERSION / ARCHITECTURAL SERVI	2003	\$ 1,575	\$ 315	5	\$ 315	\$	\$ 1,103	37
38	DESC: LIFE SAFTEY CODE CERTIFICATION	2003	90	18	5	18		63	38
39	DESC: NINE NEW SMOKE DETECTORS	2003	5,734	573	10	573		2,007	39
40	DESC: CARPET FOR LOBBY	2003	1,063	213	5	213		744	40
41	DESC: CONSTRUCTION ADMINISTRATION-SPRINKLE	2003	315	63	5	63		221	41
42	CEILING REPAIR	2003	2,041	204	10	204		714	42
43	DESC: REGRADE/RESOIL EMPLOYEE PARKING LOT	2003	7,197	720	10	720		2,519	43
44	DESC: FIRE PROTECTION SYSTEM	2003	79,026	7,903	10	7,903		23,708	44
45	DESC: SPRINKLER SYSTEM	2003	32,123	1,285	25	1,285		3,855	45
46	DESC: HEATING AND COOLING HVAC UNITS	2003	42,000	2,800	15	2,800		8,400	46
47	DESC: ADDITIONAL SMOKE DETECTORS	2003	3,649	365	10	365		1,095	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)		\$ 4,887,045	\$ 172,655		\$ 172,655	\$	\$ 2,708,296	70

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

Facility Name &amp; ID Number Provena Our Lady of Victory

# 0041723

Report Period Beginning:

01/01/06

Ending:

12/31/06

**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	<b>Totals from Page 12A, Carried Forward</b>		\$ 4,887,045	\$ 172,655		\$ 172,655	\$ (0)	\$ 2,708,296	1
2	DESC: EMERGENCY GENERATOR	2004	5,363	1,073	5	1,073		2,681	2
3	DESC: DESIGN FOR SPRINKLER PROJECT	2004	90	5	20	5		11	3
4	DESC: SPRINKLER SYSTEM	2004	40,889	1,636	25	1,636		4,072	4
5	DESC: SPRINKLER	2004	2,126	85	25	85		213	5
6	DESC: AIR COMPRESSOR FOR SPRINKLER PROJECT	2004	1,855	124	15	124		247	6
7	DESC: SPRINKLER SYSTEM PHASE 3 AND 4	2004	585	117	5	117		293	7
8	DESC: PAINTING WORK FOR SPRINKLER PROJECT	2004	3,631	726	5	726		1,815	8
9	DESC: IDPH FINAL PUNCH LIST ITEMS	2004	1,538	103	15	103		256	9
10	DESC: SPRINKLER SYSTEM PHASE 3 AND 4	2004	135	27	5	27		68	10
11	DESC: B & F REVIEW FOR SPRINKLER	2004	462	92	5	92		231	11
12	DESC: CONSTRUCTION ADMIN - OLOV SPRINKLER	2004	45	9	5	9		23	12
13	DESC: CARPET-ENTRANCE,LOBBY,C&D CORRIDOR,N	2004	43,622	8,724	5	8,724		17,449	13
14	DESC: EXTERIOR PAINTING	2004	2,825	565	5	565		1,413	14
15	DESC: CONNECT BATHROOM EXHAUST FANS, CIRCU	2004	1,989	398	5	398		995	15
16	DESC: DESIGN FOR SPRINKLER SYSTEM PHASE 3	2004	90	18	5	18		45	16
17	DESC: COOLING UNIT FOR FRONT LOBBY	2004	12,900	1,290	10	1,290		3,225	17
18	DESC: 2 DRY SPRINKLERS IN ELECTRICAL ROOM	2004	1,363	136	10	136		341	18
19	DESC: REMOVE / REPLACE EXHAUST FANS	2004	14,741	983	15	983		2,457	19
20	DESC: SPRINKLER PROJECT	2004	45	9	5	9		18	20
21	DESC: ELECTRICAL INSTALLATION FOR BATHROOM	2004	2,255	226	10	226		564	21
22	DESC: MOVED DRY PENDENT IN VESTIBULE AND A	2004	1,632	163	10	163		408	22
23	DESC: FLEXIBLE DUCT REPLACEMENT	2004	2,366	237	10	237		592	23
24	DESC: REMODEL BATHROOMS	2004	34,166	2,278	15	2,278		5,694	24
25	DESC: RELOCATE 2 PULL FIRE ALARMS, INSTALL	2004	3,942	788	5	788		1,971	25
26	DESC: AWNING FOR TLC ENTRANCE	2004	4,300	287	15	287		717	26
27	DESC: BATHROOM RENOVATION	2004	80,548	5,370	15	5,370		13,425	27
28	DESC: VINYL GRAPHICS TO 2 AWNINGS	2004	380	38	10	38		95	28
29	DESC: GENERATOR INSPECTION & REPAIR	2004	1,534	307	5	307		767	29
30	DESC: INSTALL THREE APMPERAGE ON GENERATOR	2004	740	106	7	106		211	30
31	DESC: INSTALL A/C IN ACTIVITY ROOM	2004	11,500	1,150	10	1,150		2,300	31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 5,164,702	\$ 199,722		\$ 199,722	\$ (0)	\$ 2,770,891	34

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

Facility Name &amp; ID Number Provena Our Lady of Victory

# 0041723

Report Period Beginning:

01/01/06

Ending:

12/31/06

**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	<b>Totals from Page 12B, Carried Forward</b>		\$ 5,164,702	\$ 199,722		\$ 199,722	\$ 1	\$ 2,770,891	1
2	DESC: (2) STEELCRAFT WINDOWS	2005	761	152	5	152		228	2
3	DESC: (6) 120V RECEPTICLES FOR THERAPY ROO	2005	2,600	260	10	260		390	3
4	DESC: CONNECT 2 FURNACES TO EMERGENCY GENE	2005	7,952	795	10	795		1,193	4
5	DESC: REPAVING OF PARKING LOT	2005	10,996	1,375	8	1,375		2,062	5
6	DESC: INSTALLATION OF EMERGENCY GENERATOR	2005	6,996	1,399	5	1,399		2,099	6
7	DESC: MOVE SIGN TO CORNER	2005	1,500	300	5	300		450	7
8	DESC: TREE & STUMP REMOVAL	2005	1,500	300	5	300		450	8
9	DESC: STEELCRAFT ENTRANCE PAK	2005	2,215	222	10	222		332	9
10	DESC: PHONE SYSTEM EXPANSION	2005	991	66	15	66		99	10
11	DESC: SIGN ON CORNER AND RELOCATE FLAG POL	2005	1,972	197	10	197		296	11
12	DESC: REPAVE PARKING LOT	2005	5,248	656	8	656		656	12
13	DESC: LANDSCAPING	2005	13,000	1,300	10	1,300		1,950	13
14	DESC: KM SYSTEMS 2100 & 3100 SERIES ELECTR	2005	8,119	812	10	812		1,218	14
15	DESC: ELECTRICAL - 110 V WIRING FOR FUTURE	2005	2,841	142	20	142		213	15
16									16
17	DESC: FIX DAMAGED CEILING	2006	12,750	1,275	5	2,550	1,275	1,275	17
18	DESC: CLOSET DOORS	2006	5,667	189	15	378	189	189	18
19	DESC: SIDEWALKS	2006	13,687	456	15	912	456	456	19
20	DESC: POUR AND FINISH CONCRETE FOR WALK RE	2006	1,471	49	15	98	49	49	20
21	DESC: RESAEALING AND STRIPING OF PARKING L	2006	9,659	483	10	966	483	483	21
22	DESC: PATCH/PAINT FRONT ENTRANCE,RECEPTION	2006	3,300	330	5	660	330	330	22
23	DESC: NEW HOLLOW METAL DOOR	2006	1,984	50	20	99	50	50	23
24	DESC: PLATE WARMERS IN KITCHEN	2006	1,834	92	10	183	92	92	24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 5,281,745	\$ 210,621		\$ 213,545	\$ 2,924	\$ 2,785,450	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: 01/01/06 Ending: 12/31/06

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	\$ 245,178	\$ 25,474	\$ 25,474	\$	9	\$ 105,761	71
72	Current Year Purchases	122,714	6,461	13,635	7,174	9	6,461	72
73	Fully Depreciated Assets	297,225					297,225	73
74	Home Office Allocation		58,634	58,634				74
75	TOTALS	\$ 665,117	\$ 90,569	\$ 97,743	\$ 7,174		\$ 409,447	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	\$ 42,103	76
77										77
78										78
79										79
80	TOTALS			\$ 44,910	\$ 5,614	\$ 5,614	\$		\$ 42,103	80

E. Summary of Care-Related Assets

	1	Reference	2	Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)		\$ 6,129,775	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 306,804	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 316,902	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$ 10,098	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 3,237,000	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:				\$ <u>624</u>			3
4	Additions							4
5	Home Office Allocation				<u>6,860</u>			5
6								6
7	<b>TOTAL</b>				\$ <u>7,484</u>			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.	_____ /2007	\$ _____
13.	_____ /2008	\$ _____
14.	_____ /2009	\$ _____

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: \$ 19,462 Description: Nursing \$12,030, Admin \$6,815, Home Office \$617

(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	<u>N/A</u>		\$ _____	\$ _____	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$ _____	\$ _____	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: 01/01/06 Ending: 12/31/06

**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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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)	
<b>TOTAL TRAINED</b>	

- (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.

## 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	\$	3,036	\$ 158,474	\$	3,036	\$ 158,474	1
2	Licensed Speech and Language Development Therapist	10a,3	hrs		1,750	91,340		1,750	91,340	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a,3	hrs		3,716	193,971		3,716	193,971	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts				370,351		370,351	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	<b>TOTAL</b>			\$	8,502	\$ 443,785	\$ 370,351	8,502	\$ 814,136	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: 01/01/06

Ending:

12/31/06

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/06

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 9,196,621	\$	1
2	Cash-Patient Deposits	104,225		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	10,284,617		3
4	Supply Inventory (priced at )	527,496		4
5	Short-Term Investments			5
6	Prepaid Insurance	17,880		6
7	Other Prepaid Expenses	180,330		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 20,311,169	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	6,785,655		12
13	Land	6,865,930		13
14	Buildings, at Historical Cost	81,049,403		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	17,957,954		16
17	Accumulated Depreciation (book methods)	(48,335,409)		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>	126,984		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 64,450,517	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 84,761,686	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 3,462,064	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,875,684		28
29	Short-Term Notes Payable	38,451		29
30	Accrued Salaries Payable	2,295,855		30
31	Accrued Taxes Payable (excluding real estate taxes)	68,182		31
32	Accrued Real Estate Taxes(Sch.IX-B)	676,390		32
33	Accrued Interest Payable	32,958		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Due to Related Party</u>	595,505		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 9,045,089	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	1,289,822		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	276,292		42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>Conditional Asset Retirement</u>	647,900		43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 2,214,014	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 11,259,103	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 73,502,582	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 84,761,685	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 74,753,215	1
2	Restatements (describe):		2
3	Transfer to Affiliates	(3,000,000)	3
4	Adj. To reconcile consolidated equity & consolidated income	1,620,192	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 73,373,407	6
	<b>A. Additions (deductions):</b>		
7	NET Income (Loss) (from page 19, line 43)	(127,022)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock	85,263	9
10	Stock Options Exercised		10
11	Contributions and Grants	381,287	11
12	Expenditures for Specific Purposes	(210,353)	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)	\$ 129,175	17
	<b>B. Transfers (Itemize):</b>		
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)	\$ 73,502,582	24 *

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

Facility Name & ID Number Provena Our Lady of Victory# 0041723Report Period Beginning: 01/01/06Ending: 12/31/06**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 4,433,597	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 4,433,597	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,099,790	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 1,099,790	8
<b>C. Other Operating Revenue</b>			
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	6,182	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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 6,182	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	74,255	24
25	Interest and Other Investment Income***	541	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 74,796	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Purchase Rebates</u>	167,399	28
28a	<u>Misc. Income</u>	10,395	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 177,794	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 5,792,159	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	836,958	31
32	Health Care	2,873,619	32
33	General Administration	1,524,031	33
<b>B. Capital Expense</b>			
34	Ownership	255,639	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	370,351	35
36	Provider Participation Fee	58,583	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 5,919,181	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(127,022)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (127,022)	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: 01/01/06

Ending:

12/31/06

**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	1,512	1,594	\$ 60,478	\$ 37.94	1
2	Assistant Director of Nursing	2,154	2,314	67,072	28.99	2
3	Registered Nurses	8,788	9,320	239,015	25.65	3
4	Licensed Practical Nurses	26,283	28,184	580,155	20.58	4
5	CNAs & Orderlies	63,483	66,739	720,987	10.80	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,043	7,397	85,485	11.56	8
9	Activity Director	1,892	2,080	31,182	14.99	9
10	Activity Assistants	2,896	3,174	26,852	8.46	10
11	Social Service Workers	1,960	2,080	26,912	12.94	11
12	Dietician	1,936	2,084	42,369	20.33	12
13	Food Service Supervisor	748	773	8,621	11.15	13
14	Head Cook	2,326	2,666	29,471	11.05	14
15	Cook Helpers/Assistants	16,682	17,639	127,210	7.21	15
16	Dishwashers					16
17	Maintenance Workers	3,868	4,213	56,675	13.45	17
18	Housekeepers	14,054	15,718	132,226	8.41	18
19	Laundry	1,936	2,143	20,534	9.58	19
20	Administrator	1,936	2,080	97,477	46.86	20
21	Assistant Administrator					21
22	Other Administrative	7,209	7,864	143,964	18.31	22
23	Office Manager					23
24	Clerical	4,635	5,158	40,098	7.77	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>	1,952	2,080	32,843	15.79	33
34	TOTAL (lines 1 - 33)	173,293	185,300	\$ 2,569,626 *	\$ 13.87	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	145	\$ 10,381	1,3	35
36	Medical Director	\$600/mo	7,200	9,3	36
37	Medical Records Consultant	16	920	10,3	37
38	Nurse Consultant	48	4,291	10,3	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	10	605	11,3	44
45	Social Service Consultant	20	1,180	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	239	\$ 24,577		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	1,853	\$ 90,209	10,3	50
51	Licensed Practical Nurses	7,467	298,152	10,3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	9,320	\$ 388,361		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. \$ 31,301 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. \$ 58,583  
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, 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 \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.