

		FOR BHF USE				

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**2007**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2007)**

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

**I. IDPH License ID Number:** 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 01/01/07 to 12/31/07 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: 01/01/07 Ending: 12/31/07

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds \_\_\_\_\_

	1	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	107	Skilled (SNF)	107	39,055	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	107	TOTALS	107	39,055	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	23,452	3,104	8,377	34,933	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	23,452	3,104	8,377	34,933	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.45%

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

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

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

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

N/A - None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES  NO

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 8,377

Medicare Intermediary Administar Federal

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/07 Fiscal Year: 12/31/07

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

Facility Name & ID Number Provena Our Lady of Victory # 0041723 Report Period Beginning: 01/01/07 Ending: 12/31/07

**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 BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	221,050	22,605	9,283	252,938		252,938		252,938		1
2	Food Purchase		164,691		164,691		164,691	3,034	167,725		2
3	Housekeeping	161,538	14,468	148	176,154		176,154		176,154		3
4	Laundry	20,877	8,100		28,977		28,977		28,977		4
5	Heat and Other Utilities			152,119	152,119		152,119	1,390	153,509		5
6	Maintenance	66,316	14,728	62,767	143,811		143,811	16,506	160,317		6
7	Other (specify):* <b>Pastoral Care</b>	33,649	97	19,129	52,875		52,875	19,136	72,011		7
8	<b>TOTAL General Services</b>	503,430	224,689	243,446	971,565		971,565	40,066	1,011,631		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			7,200	7,200		7,200		7,200		9
10	Nursing and Medical Records	2,098,534	136,990	78,913	2,314,437		2,314,437		2,314,437		10
10a	Therapy			566,108	566,108		566,108		566,108		10a
11	Activities	64,095	1,917	11,341	77,353		77,353	434	77,787		11
12	Social Services	41,316		750	42,066		42,066		42,066		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	2,203,945	138,907	664,312	3,007,164		3,007,164	434	3,007,598		16
	<b>C. General Administration</b>										
17	Administrative	215,282	11,864	662,040	889,186		889,186	(196,732)	692,454		17
18	Directors Fees										18
19	Professional Services			6,297	6,297		6,297	120,528	126,825		19
20	Dues, Fees, Subscriptions & Promotions			36,059	36,059		36,059	(771)	35,288		20
21	Clerical & General Office Expenses			149,281	149,281		149,281	7,560	156,841		21
22	Employee Benefits & Payroll Taxes			613,535	613,535		613,535	75,994	689,529		22
23	Inservice Training & Education			5,982	5,982		5,982	3,607	9,589		23
24	Travel and Seminar			7,350	7,350		7,350	5,153	12,503		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			84,384	84,384		84,384	951	85,335		26
27	Other (specify):* <b>Bad Debt</b>			49,728	49,728		49,728	(49,728)			27
28	<b>TOTAL General Administration</b>	215,282	11,864	1,614,656	1,841,802		1,841,802	(33,438)	1,808,364		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,922,657	375,460	2,522,414	5,820,531		5,820,531	7,062	5,827,593		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: 01/01/07 Ending: 12/31/07

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			233,929	233,929	233,929	85,608	319,537				30
31	Amortization of Pre-Op. & Org.											31
32	Interest						145,588	145,588				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds						12,365	12,365				34
35	Rent-Equipment & Vehicles			5,361	5,361	5,361	1,682	7,043				35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			239,290	239,290	239,290	245,243	484,533				37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			502,007	502,007	502,007	(205,684)	296,323				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			58,422	58,422	58,422		58,422				42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			560,429	560,429	560,429	(205,684)	354,745				44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,922,657	375,460	3,322,133	6,620,250	6,620,250	46,621	6,666,871				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:

01/01/07

Ending:

12/31/07

**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	BHF 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	8,057	30		9
10	Interest and Other Investment Income	(6,270)	32		10
11	Discounts, Allowances, Rebates & Refunds	(205,684)	39		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				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	(49,728)	27		24
25	Fund Raising, Advertising and Promotional	(7,685)	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>	\$ (261,310)		\$	30

BHF USE ONLY					
48		49		50	
				51	
					52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	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)	288,795		34
35	Other- Attach Schedule	(19,136)		35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 269,659		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ 8,349		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

Provena Our Lady of Victory

ID# 0041723

Report Period Beginning: 01/01/07

Ending: 12/31/07

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	Development Office Supplies	\$ 5	7 1
2	Development Printed Publications	5	7 2
3	Development Food	41	7 3
4	Development Freight	31	7 4
5	Development Other Purchased Services	183	7 5
6	Development Misc	18,871	7 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>	19,136	49

## STATE OF ILLINOIS

Summary A

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

# 0041723

Report Period Beginning:

01/01/07

Ending:

12/31/07

## 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	3,034	0	0	0	0	0	0	0	0	0	3,034	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	1,390	0	0	0	0	0	0	0	0	0	1,390	5
6	Maintenance	0	366	16,140	0	0	0	0	0	0	0	0	16,506	6
7	Other (specify):*	19,136	0	0	0	0	0	0	0	0	0	0	19,136	7
8	<b>TOTAL General Services</b>	<b>19,136</b>	<b>4,790</b>	<b>16,140</b>	<b>0</b>	<b>40,066</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	434	0	0	0	0	0	0	0	0	0	434	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>434</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>434</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	(297,546)	100,814	0	0	0	0	0	0	0	0	(196,732)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	50,112	70,416	0	0	0	0	0	0	0	0	120,528	19
20	Fees, Subscriptions & Promotions	(7,685)	6,914	0	0	0	0	0	0	0	0	0	(771)	20
21	Clerical & General Office Expenses	0	7,560	0	0	0	0	0	0	0	0	0	7,560	21
22	Employee Benefits & Payroll Taxes	0	40,245	35,749	0	0	0	0	0	0	0	0	75,994	22
23	Inservice Training & Education	0	3,607	0	0	0	0	0	0	0	0	0	3,607	23
24	Travel and Seminar	0	5,153	0	0	0	0	0	0	0	0	0	5,153	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	951	0	0	0	0	0	0	0	0	0	951	26
27	Other (specify):*	(49,728)	0	0	0	0	0	0	0	0	0	0	(49,728)	27
28	<b>TOTAL General Administration</b>	<b>(57,413)</b>	<b>(183,004)</b>	<b>206,979</b>	<b>0</b>	<b>(33,438)</b>	<b>28</b>							
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(38,277)</b>	<b>(177,780)</b>	<b>223,119</b>	<b>0</b>	<b>7,062</b>	<b>29</b>							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Provena Our Lady of Victory

# 0041723

Report Period Beginning:

01/01/07 Ending:

12/31/07

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	8,057	0	77,551	0	0	0	0	0	0	0	0	85,608	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(6,270)	0	151,858	0	0	0	0	0	0	0	0	145,588	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	12,365	0	0	0	0	0	0	0	0	12,365	34
35	Rent-Equipment & Vehicles	0	0	1,682	0	0	0	0	0	0	0	0	1,682	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>1,787</b>	<b>0</b>	<b>243,456</b>	<b>0</b>	<b>245,243</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	(205,684)	0	0	0	0	0	0	0	0	0	0	(205,684)	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>(205,684)</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>(205,684)</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(242,174)</b>	<b>(177,780)</b>	<b>466,575</b>	<b>0</b>	<b>46,621</b>	<b>45</b>							

Facility Name & ID Number Provena Our Lady of Victory

# 0041723

Report Period Beginning:

01/01/07

Ending:

12/31/07

**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 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)
1	V	2 Food	\$	Provena Senior Services	100.00%	\$ 3,034	\$ 3,034 1
2	V	5 Utilities		Provena Senior Services	100.00%	1,390	1,390 2
3	V	6 Maintenance - Other		Provena Senior Services	100.00%	366	366 3
4	V	11 Activities-Special Events		Provena Senior Services	100.00%	434	434 4
5	V	17 Admin - Misc. Other	455,520	Provena Senior Services	100.00%	9,085	(446,435) 5
6	V	17 Administrative Services		Provena Senior Services	100.00%	148,889	148,889 6
7	V	19 Professional Services		Provena Senior Services	100.00%	50,112	50,112 7
8	V	20 Dues,Subscriptions		Provena Senior Services	100.00%	6,914	6,914 8
9	V	21 Clerical Supplies		Provena Senior Services	100.00%	7,560	7,560 9
10	V	22 Employee Benefits		Provena Senior Services	100.00%	40,245	40,245 10
11	V	23 Education/Conference		Provena Senior Services	100.00%	3,607	3,607 11
12	V	24 Travel		Provena Senior Services	100.00%	5,153	5,153 12
13	V	26 Insurance		Provena Senior Services	100.00%	951	951 13
14	Total		\$ 455,520			\$ 277,740	\$ * (177,780) 14

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

Facility Name & ID Number Provena Our Lady of Victory# 0041723Report Period Beginning: 01/01/07Ending: 12/31/07

## 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%	\$ 2,684	\$ 2,684	15
16	V	32	Interest		Provena Senior Services	100.00%	151,858	151,858	16
17	V	34	Rent - Facility		Provena Senior Services	100.00%	12,365	12,365	17
18	V	35	Rent - Equipment		Provena Senior Services	100.00%	1,682	1,682	18
19	V	17	Admin Salaries	85,320	Provena Health Services	100.00%	68,514	(16,806)	19
20	V	22	Employee Benefits		Provena Health Services	100.00%	16,126	16,126	20
21	V	30	Depreciation		Provena Health Services	100.00%	74,867	74,867	21
22	V	19	Admin Consulting,Other		Provena Health Services	100.00%	70,416	70,416	22
23	V	17	Information Systems Salaries	121,200	Provena Health Services	100.00%	23,321	(97,879)	23
24	V	22	Information Systems Benefits		Provena Health Services	100.00%	5,348	5,348	24
25	V	17	Information Systems - Other		Provena Health Services	100.00%	154,853	154,853	25
26	V	17	Admin Salaries		Provena Health Services	100.00%	32,608	32,608	26
27	V	22	Employee Benefits		Provena Health Services	100.00%	7,675	7,675	27
28	V	17	Information Systems Salaries		Provena Health Services	100.00%	28,038	28,038	28
29	V	22	Information Systems Benefits		Provena Health Services	100.00%	6,600	6,600	29
30	V	6	Information Systems - Equip Maint		Provena Health Services	100.00%	16,140	16,140	30
31	V	39	Ancillary Services - Other	502,007	Provena Senior Services Pharmacy	100.00%	502,007		31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 708,527			\$ 1,175,102	\$ * 466,575	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: 01/01/07 Ending: 12/31/07

## 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: 01/01/07

Ending: 12/31/07

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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	6,620,619	19	\$ 44,100	\$ 455,520	\$ 3,034	1
2	5	Utilities	Management Fee Income	6,620,619	19	20,208	455,520	1,390	2
3	6	Maintenance - Other	Management Fee Income	6,620,619	19	5,313	455,520	366	3
4	11	Activities-Special Events	Management Fee Income	6,620,619	19	6,306	455,520	434	4
5	17	Admin - Misc. Other	Management Fee Income	6,620,619	19	132,045	455,520	9,085	5
6	17	Administrative Salaries	Management Fee Income	6,620,619	19	2,163,976	2,163,976	148,889	6
7	19	Professional Services	Management Fee Income	6,620,619	19	728,345	455,520	50,112	7
8	20	Dues,Subscriptions	Management Fee Income	6,620,619	19	100,486	455,520	6,914	8
9	21	Clerical Supplies	Management Fee Income	6,620,619	19	109,877	455,520	7,560	9
10	22	Employee Benefits	Management Fee Income	6,620,619	19	584,930	455,520	40,245	10
11	23	Education/Conference	Management Fee Income	6,620,619	19	52,430	455,520	3,607	11
12	24	Travel	Management Fee Income	6,620,619	19	74,891	455,520	5,153	12
13	26	Insurance	Management Fee Income	6,620,619	19	13,824	455,520	951	13
14	30	Depreciation	Management Fee Income	6,620,619	19	39,013	455,520	2,684	14
15	32	Interest	Management Fee Income	6,620,619	19	2,207,136	455,520	151,858	15
16	34	Rent - Facility	Management Fee Income	6,620,619	19	179,713	455,520	12,365	16
17	35	Rent - Equipment	Management Fee Income	6,620,619	19	24,448	455,520	1,682	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 6,487,041	\$ 2,163,976	\$ 446,329	25

Facility Name & ID Number Provena Our Lady of Victory

# 0041723

Report Period Beginning:

01/01/07

Ending: 12/31/07

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	1,239,804	10	\$ 995,585	\$ 995,585	85,320	\$ 68,514	1
2	22	Employee Benefits	Operating Expense	1,239,804	10	234,337		85,320	16,126	2
3	30	Depreciation	Operating Expense	1,239,804	10	1,087,913		85,320	74,867	3
4	19	Admin Consulting,Other	Operating Expense	1,239,804	10	1,023,231		85,320	70,416	4
5	17	Information Systems Salaries	Operating Expense	1,759,764	10	338,615	338,615	121,200	23,321	5
6	22	Information Systems Benefits	Operating Expense	1,759,764	10	77,649		121,200	5,348	6
7	17	Information Systems - Other	Operating Expense	1,759,764	10	2,248,393		121,200	154,853	7
8	17	Admin Salaries	Direct Cost	1,239,804	10	473,834	473,834	85,320	32,608	8
9	22	Employee Benefits	Direct Cost	1,239,804	10	111,529		85,320	7,675	9
10	17	Information Systems Salaries	Direct Cost	1,759,764	10	407,099	407,099	121,200	28,038	10
11	22	Information Systems Benefits	Direct Cost	1,759,764	10	95,822		121,200	6,600	11
12	6	Information Systems - Equip Main	Direct Cost	1,759,764	10	234,347		121,200	16,140	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					\$ 7,328,354	\$ 2,215,133		\$ 504,506	25

Facility Name & ID Number Provena Our Lady of Victory

# 0041723

Report Period Beginning: 01/01/07

Ending: 12/31/07

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		\$	\$		\$ 502,007	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				\$	\$		\$ 502,007	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	Home Office Allocation									\$ 151,858	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>					\$	\$			\$ 151,858	9									
<b>B. Non-Facility Related*</b>																				
10											10									
11											11									
12											12									
13											13									
14	<b>TOTAL Non-Facility Related</b>					\$	\$			\$	14									
15	<b>TOTALS (line 9+line14)</b>					\$	\$			\$ 151,858	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.)

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2006 report.		<b>Important</b> , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)				\$	2
3. Under or (over) accrual (line 2 minus line 1).				\$	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>				\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>				\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:					
2002	_____	8			
2003	_____	9			
2004	_____	10			
2005	_____	11			
2006	_____	12			
			<b>FOR BHF USE ONLY</b>		
13	FROM R. E. TAX STATEMENT FOR 2006	\$		13	
14	PLUS APPEAL COST FROM LINE 5	\$		14	
15	LESS REFUND FROM LINE 6	\$		15	
16	AMOUNT TO USE FOR RATE CALCULATION	\$		16	

NOTES:

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

**2006 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 2006 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 2006.

(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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

**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:

01/01/07 Ending:

12/31/07

**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					2
3	<b>TOTALS</b>			<b>\$ 135,000</b>	3

Facility Name & ID Number Provena Our Lady of Victory

# 0041723

Report Period Beginning:

01/01/07

Ending:

12/31/07

**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	\$	25	\$	\$	\$ 507,112	4
5	8			1984	726,964	29,079	25	29,079		697,450	5
6	9			1987	33,355		15			33,355	6
7	10			1995	2,520,706	64,282	35	64,282		793,906	7
8											8
	<b>Improvement Type**</b>										
9	Various			1982	95,473	1,909	25	1,909		95,473	9
10	Various			1985	300		15			300	10
11	Various			1986	45,673	1,224	21	1,224		45,673	11
12	Various			1987	14,973	713	21	713		14,613	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		9,113	17
18	Various			1994	3,258		8			3,258	18
19	Various			1995	8,996		5			8,996	19
20	Various			1996	192,299	9,921	11	9,921		123,378	20
21	Various			1997	104,421	982	5	982		104,421	21
22	Various			1998	48,287		5			48,287	22
23	Various			1999	74,075	3,186	6	3,186		58,502	23
24	Various			2000	25,153	1,492	7	1,492		21,650	24
25	Various			2001	107,190	8,159	6	8,159		78,635	25
26	Various			2002	67,798	7,142	9	7,142		41,258	26
27	Various			2003	175,875	15,035	10	15,035		62,137	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 &amp; ID Number Provena Our Lady of Victory

# 0041723

Report Period Beginning:

01/01/07

Ending:

12/31/07

**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	BATHROOM RENOVATION	2004	\$ 80,548	\$ 5,370	15	\$ 5,370	\$	\$ 18,795	37
38	SPRINKLER SYSTEM	2004	40,889	1,636	25	1,636		5,707	38
39	REMODEL BATHROOMS	2004	34,166	2,278	15	2,278		7,972	39
40	REMOVE / REPLACE EXHAUST	2004	14,741	983	15	983		3,440	40
41	COOLING UNIT FOR FRONT L	2004	12,900	1,290	10	1,290		4,515	41
42	EMERGENCY GENERATOR	2004	5,363	1,073	5	1,073		3,754	42
43	AWNING FOR TLC ENTRANCE	2004	4,300	287	15	287		1,003	43
44	RELOCATE 2 PULL FIRE ALA	2004	3,942	788	5	788		2,760	44
45	ADDITIONAL SMOKE DETECTO	2004	3,649	365	10	365		1,460	45
46	PAINTING WORK FOR SPRINK	2004	3,631	726	5	726		2,541	46
47	EXTERIOR PAINTING	2004	2,825	565	5	565		1,978	47
48	FLEXIBLE DUCT REPLACEMEN	2004	2,366	237	10	237		828	48
49	ELECTRICAL INSTALLATION	2004	2,255	226	10	226		789	49
50	SPRINKLER	2004	2,126	85	25	85		298	50
51	CONNECT BATHROOM EXHAUST	2004	1,989	398	5	398		1,393	51
52	MOVED DRY PENDENT IN VES	2004	1,632	163	10	163		571	52
53	IDPH FINAL PUNCH LIST IT	2004	1,538	103	15	103		359	53
54	GENERATOR INSPECTION & R	2004	1,534	307	5	307		1,074	54
55	2 DRY SPRINKLERS IN ELEC	2004	1,363	136	10	136		477	55
56	SPRINKLER SYSTEM PHASE 3	2004	585	117	5	117		410	56
57	B & F REVIEW FOR SPRINKL	2004	462	92	5	92		323	57
58	VINYL GRAPHICS TO 2 AWNI	2004	380	38	10	38		133	58
59	SPRINKLER SYSTEM PHASE 3	2004	135	27	5	27		95	59
60	DESIGN FOR SPRINKLER PRO	2004	90	5	20	5		16	60
61	DESIGN FOR SPRINKLER SYS	2004	90	18	5	18		63	61
62	CONSTRUCTION ADMIN - OLO	2004	45	9	5	9		32	62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 5,106,517	\$ 161,051		\$ 161,051	\$	\$ 2,927,215	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:

01/01/07

Ending:

12/31/07

**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>		\$ 5,106,517	\$ 161,051		\$ 161,051	\$	\$ 2,927,215	1
2	CARPET-ENTRANCE,LOBBY,C&	2005	43,622	8,724	5	8,724		26,173	2
3	LANDSCAPING	2005	13,000	1,300	10	1,300		3,250	3
4	INSTALL A/C IN ACTIVITY	2005	11,500	1,150	10	1,150		3,450	4
5	REPAVING OF PARKING LOT	2005	10,996	1,375	8	1,375		3,436	5
6	KM SYSTEMS 2100 & 3100 S	2005	8,119	812	10	812		2,030	6
7	CONNECT 2 FURNACES TO EM	2005	7,952	795	10	795		1,988	7
8	INSTALLATION OF EMERGENC	2005	6,996	1,399	5	1,399		3,498	8
9	ELECTRICAL - 110 V WIRIN	2005	2,841	142	20	142		355	9
10	(6) 120V RECEPTICLES FOR	2005	2,600	260	10	260		650	10
11	STEELCRAFT ENTRANCE PAK	2005	2,215	222	10	222		554	11
12	SIGN ON CORNER AND RELOC	2005	1,972	197	10	197		493	12
13	AIR COMPRESSOR FOR SPRIN	2005	1,855	124	15	124		371	13
14	MOVE SIGN TO CORNER	2005	1,500	300	5	300		750	14
15	TREE & STUMP REMOVAL	2005	1,500	300	5	300		750	15
16	PHONE SYSTEM EXPANSION	2005	991	66	15	66		165	16
17	(2) STEELCRAFT WINDOWS	2005	761	152	5	152		381	17
18	INSTALL THREE APMPERAGE	2005	740	106	7	106		317	18
19	SPRINKLER PROJECT	2005	45	9	5	9		27	19
20									20
21	SIDEWALKS	2006	13,687	912	15	912		1,369	21
22	FIX DAMAGED CEILING	2006	12,750	2,550	5	2,550		3,825	22
23	RESAEALING AND STRIPING	2006	9,659	966	10	966		1,449	23
24	CLOSET DOORS	2006	5,667	378	15	378		567	24
25	REPAVE PARKING LOT	2006	5,248	656	8	656		1,312	25
26	PATCH/PAINT FRONT ENTRAN	2006	3,300	660	5	660		990	26
27	NEW HOLLOW METAL DOOR	2006	1,984	99	20	99		149	27
28	PLATE WARMERS IN KITCHEN	2006	1,834	183	10	183		275	28
29	POUR AND FINISH CONCRETE	2006	1,471	98	15	98		147	29
30									30
31	PANLFORD FOLDING PARTIT	2007	13,206	660	10	1,321	660	660	31
32	WATER HEATER REPAIRS	2007	5,250	525	10	1,050	525	525	32
33	REDECORATING PROJECT	2007	4,919	492	5	984	492	492	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 5,304,697	\$ 186,664		\$ 188,341	\$ 1,677	\$ 2,987,612	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: 01/01/07 Ending: 12/31/07

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	\$ 343,859	\$ 38,078	\$ 38,078	\$	9	\$ 126,550	71
72	Current Year Purchases	122,656	6,380	12,760	6,380	10	6,380	72
73	Fully Depreciated Assets	315,414				6	314,863	73
74	Home Office Allocation		77,551	77,551				74
75	TOTALS	\$ 781,929	\$ 122,009	\$ 128,389	\$ 6,380		\$ 447,793	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	Plant Engineering	1999 Ford Eldorado	1999	\$ 44,910	\$ 2,807	\$ 2,807	\$	8	\$ 44,910	76
77										77
78										78
79										79
80	TOTALS			\$ 44,910	\$ 2,807	\$ 2,807	\$		\$ 44,910	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)	\$	6,266,536	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	311,480	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$	319,537	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	8,057	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$	3,480,315	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:				\$ _____			3
4	Additions				_____			4
5	Home Office Allocation				12,365			5
6					_____			6
7	TOTAL				\$ 12,365			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.	_____ /2008	\$ _____
13.	_____ /2009	\$ _____
14.	_____ /2010	\$ _____

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: \$ 18,885 Description: Nursing \$11921, Plant Eng. \$74, Admin \$5208, Home Office \$1682

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

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

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

**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)	
<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.

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

Report Period Beginning:

01/01/07

Ending:

12/31/07

## 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	\$	4,576	\$ 247,092	\$	4,576	\$ 247,092	1
2	Licensed Speech and Language Development Therapist	10a, 3	hrs		1,249	67,432		1,249	67,432	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a, 3	hrs		4,659	251,584		4,659	251,584	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39, 3	# of prescripts				502,007		502,007	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>			\$	10,483	\$ 566,108	\$ 502,007	10,483	\$ 1,068,115	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: 01/01/07

Ending:

12/31/07

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/07

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 8,785,520	\$	1
2	Cash-Patient Deposits	113,303		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	11,176,143		3
4	Supply Inventory (priced at )	533,002		4
5	Short-Term Investments			5
6	Prepaid Insurance	16,312		6
7	Other Prepaid Expenses	134,911		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>	\$ 20,759,191	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	7,331,517		12
13	Land	6,751,685		13
14	Buildings, at Historical Cost	83,408,867		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	18,112,162		16
17	Accumulated Depreciation (book methods)	(49,944,144)		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>	120,120		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 65,780,207	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 86,539,398	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 4,826,767	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,861,673		28
29	Short-Term Notes Payable	42,163		29
30	Accrued Salaries Payable	2,756,052		30
31	Accrued Taxes Payable (excluding real estate taxes)	80,845		31
32	Accrued Real Estate Taxes(Sch.IX-B)	823,060		32
33	Accrued Interest Payable	41,064		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>	817,281		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 11,248,905	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	1,247,620		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	338,908		42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>Conditional Asset Retirement</u>	450,209		43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 2,036,737	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 13,285,642	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 73,253,756	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 86,539,398	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 73,502,583	1
2	Restatements (describe):		2
3	Transfer to Affiliates	(2,361,850)	3
4	Adj. To reconcile consolidated equity & consolidated income	2,254,106	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 73,394,839	6
	<b>A. Additions (deductions):</b>		
7	NET Income (Loss) (from page 19, line 43)	(24,411)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock	(333,474)	9
10	Stock Options Exercised		10
11	Contributions and Grants	417,345	11
12	Expenditures for Specific Purposes	(200,543)	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)	\$ (141,083)	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)	\$ 73,253,756	24 *

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

Facility Name & ID Number Provena Our Lady of Victory# 0041723Report Period Beginning: 01/01/07Ending: 12/31/07**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	\$ 4,969,471	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 4,969,471	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	892,143	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 892,143	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	17,143	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	445,603	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>	\$ 462,746	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	46,497	24
25	Interest and Other Investment Income***	6,270	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 52,767	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Purchase Rebates</u>	205,684	28
28a	<u>Misc. Income</u>	13,028	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 218,712	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 6,595,839	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	971,565	31
32	Health Care	3,007,164	32
33	General Administration	1,841,802	33
<b>B. Capital Expense</b>			
34	Ownership	239,290	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	502,007	35
36	Provider Participation Fee	58,422	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 6,620,250	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(24,411)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (24,411)	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: 01/01/07

Ending: 12/31/07

**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	1,968	2,080	\$ 81,556	\$ 39.21	1
2	Assistant Director of Nursing	2,020	2,171	68,811	31.70	2
3	Registered Nurses	14,352	15,078	503,025	33.36	3
4	Licensed Practical Nurses	35,842	38,056	749,232	19.69	4
5	CNAs & Orderlies	64,928	68,824	695,910	10.11	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,865	2,081	32,715	15.72	9
10	Activity Assistants	3,204	3,370	31,380	9.31	10
11	Social Service Workers	2,947	3,153	41,316	13.10	11
12	Dietician	1,912	2,080	49,007	23.56	12
13	Food Service Supervisor	1,405	1,505	16,561	11.00	13
14	Head Cook	2,048	2,198	21,824	9.93	14
15	Cook Helpers/Assistants	16,385	17,416	133,658	7.67	15
16	Dishwashers					16
17	Maintenance Workers	3,933	4,165	66,316	15.92	17
18	Housekeepers	16,870	18,455	161,538	8.75	18
19	Laundry	1,935	2,127	20,877	9.82	19
20	Administrator	1,608	1,720	63,864	37.13	20
21	Assistant Administrator					21
22	Other Administrative	1,806	2,068	42,809	20.70	22
23	Office Manager	1,736	1,952	34,028	17.43	23
24	Clerical	6,656	7,161	74,581	10.41	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>	1,928	2,080	33,649	16.18	33
34	TOTAL (lines 1 - 33)	185,348	197,740	\$ 2,922,657 *	\$ 14.78	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	134	\$ 9,017	1,3	35
36	Medical Director	\$600/mo	7,200	9,3	36
37	Medical Records Consultant	12	690	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				44
45	Social Service Consultant	13	750	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	159	\$ 17,657		49

**C. CONTRACT NURSES**

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	200	\$ 10,625	10,3	50
51	Licensed Practical Nurses	226	9,958	10,3	51
52	Certified Nurse Assistants/Aides	870	21,741	10,3	52
53	TOTAL (lines 50 - 52)	1,296	\$ 42,324		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. Life Service Network \$4,749
- (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. \$ 35,504 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. \$ 58,422  
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. \$ No Has any meal income been offset against related costs? No 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.