

Facility Name & ID Number Provena Our Lady of Victory

0041723 Report Period Beginning: 01/01/08 Ending: 12/31/08

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	39,162	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	39,162	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	23,622	2,611	8,252	34,485	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	23,622	2,611	8,252	34,485	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.06%

D. How many bed-hold days during this year were paid by the Department? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

N/A - None

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

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

YES NO

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 11/6/1981

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 8,252

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/08 Fiscal Year: 12/31/08

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

Facility Name & ID Number Provena Our Lady of Victory # 0041723 Report Period Beginning: 01/01/08 Ending: 12/31/08

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	
	A. General Services											
1	Dietary	238,911	24,694	20,282	283,887		283,887		283,887			1
2	Food Purchase		182,594		182,594		182,594	2,474	185,068			2
3	Housekeeping	197,666	14,369	74	212,109		212,109		212,109			3
4	Laundry	21,590	6,421		28,011		28,011		28,011			4
5	Heat and Other Utilities			129,136	129,136		129,136	2,504	131,640			5
6	Maintenance	83,762	12,533	69,733	166,028		166,028	24,452	190,480			6
7	Other (specify):* Pastoral Care	34,702	1,180	42,463	78,345		78,345	43,461	121,806			7
8	TOTAL General Services	576,631	241,791	261,688	1,080,110		1,080,110	72,891	1,153,001			8
	B. Health Care and Programs											
9	Medical Director			6,600	6,600		6,600		6,600			9
10	Nursing and Medical Records	2,149,836	162,624	131,267	2,443,727		2,443,727		2,443,727			10
10a	Therapy			764,167	764,167		764,167		764,167			10a
11	Activities	58,763	1,729	10,101	70,593		70,593	504	71,097			11
12	Social Services	54,948		1,185	56,133		56,133		56,133			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,263,547	164,353	913,320	3,341,220		3,341,220	504	3,341,724			16
	C. General Administration											
17	Administrative	228,106	15,959	682,560	926,625		926,625	(301,946)	624,679			17
18	Directors Fees											18
19	Professional Services			6,976	6,976		6,976	39,244	46,220			19
20	Dues, Fees, Subscriptions & Promotions			25,319	25,319		25,319	(79)	25,240			20
21	Clerical & General Office Expenses			23,472	23,472		23,472	7,322	30,794			21
22	Employee Benefits & Payroll Taxes			712,275	712,275		712,275	171,797	884,072			22
23	Inservice Training & Education			8,344	8,344		8,344	2,684	11,028			23
24	Travel and Seminar			17,158	17,158		17,158	5,488	22,646			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			68,400	68,400		68,400	381	68,781			26
27	Other (specify):* Bad Debt			42,247	42,247		42,247	(42,247)				27
28	TOTAL General Administration	228,106	15,959	1,586,751	1,830,816		1,830,816	(117,356)	1,713,460			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,068,284	422,103	2,761,759	6,252,146		6,252,146	(43,961)	6,208,185			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: 01/01/08 Ending: 12/31/08

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 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
	D. Ownership										
30	Depreciation			236,527	236,527	236,527	72,991	309,518			30
31	Amortization of Pre-Op. & Org.										31
32	Interest						549,089	549,089			32
33	Real Estate Taxes										33
34	Rent-Facility & Grounds						16,922	16,922			34
35	Rent-Equipment & Vehicles			8,346	8,346	8,346	2,556	10,902			35
36	Other (specify):*										36
37	TOTAL Ownership			244,873	244,873	244,873	641,558	886,431			37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers			551,655	551,655	551,655	(268,373)	283,282			39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			58,743	58,743	58,743		58,743			42
43	Other (specify):*										43
44	TOTAL Special Cost Centers			610,398	610,398	610,398	(268,373)	342,025			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,068,284	422,103	3,617,030	7,107,417	7,107,417	329,224	7,436,641			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: 01/01/08

Ending: 12/31/08

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	8,596	30		9
10	Interest and Other Investment Income	(2,523)	32		10
11	Discounts, Allowances, Rebates & Refunds	(268,373)	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	(42,247)	27		24
25	Fund Raising, Advertising and Promotional	(6,362)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (310,909)		\$	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)	596,672		34
35	Other- Attach Schedule	43,461		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 640,133		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 329,224		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.

		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						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY					
48		49		50	51
					52

Provena Our Lady of Victory

ID# 0041723

Report Period Beginning: 01/01/08

Ending: 12/31/08

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Development - Office Supplies	\$ 1,028	7	1
2	Development - Other Supplies	31	7	2
3	Development - Food	106	7	3
4	Development - Postage	49	7	4
5	Development - Other Purchased Services	602	7	5
6	Development - Misc	41,645	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	Total	43,461		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Provena Our Lady of Victory

0041723

Report Period Beginning:

01/01/08

Ending:

12/31/08

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	2,474	0	0	0	0	0	0	0	0	0	2,474	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	2,504	0	0	0	0	0	0	0	0	0	2,504	5
6	Maintenance	0	1,140	23,312	0	0	0	0	0	0	0	0	24,452	6
7	Other (specify):*	43,461	0	0	0	0	0	0	0	0	0	0	43,461	7
8	TOTAL General Services	43,461	6,118	23,312	0	72,891	8							
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	504	0	0	0	0	0	0	0	0	0	504	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	504	0	0	0	0	0	0	0	0	0	504	16
	C. General Administration													
17	Administrative	0	(282,903)	(19,043)	0	0	0	0	0	0	0	0	(301,946)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	26,362	12,882	0	0	0	0	0	0	0	0	39,244	19
20	Fees, Subscriptions & Promotions	(6,362)	6,283	0	0	0	0	0	0	0	0	0	(79)	20
21	Clerical & General Office Expenses	0	7,322	0	0	0	0	0	0	0	0	0	7,322	21
22	Employee Benefits & Payroll Taxes	0	46,931	124,866	0	0	0	0	0	0	0	0	171,797	22
23	Inservice Training & Education	0	2,684	0	0	0	0	0	0	0	0	0	2,684	23
24	Travel and Seminar	0	5,488	0	0	0	0	0	0	0	0	0	5,488	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	381	0	0	0	0	0	0	0	0	0	381	26
27	Other (specify):*	(42,247)	0	0	0	0	0	0	0	0	0	0	(42,247)	27
28	TOTAL General Administration	(48,609)	(187,452)	118,705	0	(117,356)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(5,148)	(180,830)	142,017	0	(43,961)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Provena Our Lady of Victory

0041723

Report Period Beginning:

01/01/08 Ending:

12/31/08

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	8,596	0	64,395	0	0	0	0	0	0	0	0	72,991	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,523)	0	551,612	0	0	0	0	0	0	0	0	549,089	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	16,922	0	0	0	0	0	0	0	0	16,922	34
35	Rent-Equipment & Vehicles	0	0	2,556	0	0	0	0	0	0	0	0	2,556	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	6,073	0	635,485	0	641,558	37							
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	(268,373)	0	0	0	0	0	0	0	0	0	0	(268,373)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	(268,373)	0	0	0	0	0	0	0	0	0	0	(268,373)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(267,448)	(180,830)	777,502	0	329,224	45							

Facility Name & ID Number Provena Our Lady of Victory

0041723

Report Period Beginning:

01/01/08

Ending:

12/31/08

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%	\$ 2,474	\$ 2,474
2	V	5 Utilities		Provena Senior Services	100.00%	2,504	2,504
3	V	6 Maintenance - Other		Provena Senior Services	100.00%	1,140	1,140
4	V	11 Activities-Special Events		Provena Senior Services	100.00%	504	504
5	V	17 Admin - Misc. Other	445,320	Provena Senior Services	100.00%	(1,353)	(446,673)
6	V	17 Administrative Services		Provena Senior Services	100.00%	163,770	163,770
7	V	19 Professional Salaries		Provena Senior Services	100.00%	26,362	26,362
8	V	20 Dues,Subscriptions		Provena Senior Services	100.00%	6,283	6,283
9	V	21 Clerical Supplies		Provena Senior Services	100.00%	7,322	7,322
10	V	22 Employee Benefits		Provena Senior Services	100.00%	46,931	46,931
11	V	23 Education/Conference		Provena Senior Services	100.00%	2,684	2,684
12	V	24 Travel		Provena Senior Services	100.00%	5,488	5,488
13	V	26 Insurance		Provena Senior Services	100.00%	381	381
14	Total		\$ 445,320			\$ 264,490	\$ * (180,830)

* 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: 01/01/08Ending: 12/31/08

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%	\$ 2,473	\$ 2,473	15
16	V	32 Interest		Provena Senior Services	100.00%	214,392	214,392	16
17	V	34 Rent - Facility		Provena Senior Services	100.00%	16,922	16,922	17
18	V	35 Rent - Equipment		Provena Senior Services	100.00%	2,556	2,556	18
19	V	17 Admin Salaries	92,880	Provena Health Services	100.00%	57,880	(35,000)	19
20	V	22 Employee Benefits		Provena Health Services	100.00%	44,047	44,047	20
21	V	30 Depreciation		Provena Health Services	100.00%	61,922	61,922	21
22	V	19 Admin Consulting, Other		Provena Health Services	100.00%	12,882	12,882	22
23	V	17 Information Systems Salaries	144,360	Provena Health Services	100.00%	100,476	(43,884)	23
24	V	22 Information Systems Benefits		Provena Health Services	100.00%	26,780	26,780	24
25	V	17 Information Systems - Other		Provena Health Services	100.00%	13,657	13,657	25
26	V	17 Admin Salaries		Provena Health Services	100.00%	18,735	18,735	26
27	V	22 Employee Benefits		Provena Health Services	100.00%	29,423	29,423	27
28	V	17 Information Systems Salaries		Provena Health Services	100.00%	27,449	27,449	28
29	V	22 Information Systems Benefits		Provena Health Services	100.00%	24,616	24,616	29
30	V	6 Information Systems - Equip Maint		Provena Health Services	100.00%	23,312	23,312	30
31	V	32 Admin - Interest Expense		Provena Health Services	100.00%	337,220	337,220	31
32	V	39 Ancillary Services - Other	551,655	Provena Senior Services Pharmacy	100.00%	551,655		32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 788,895			\$ 1,566,397	\$ * 777,502	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: 01/01/08 Ending: 12/31/08

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: 01/01/08

Ending: 12/31/08

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 6,616,778	19	\$ 36,766	\$	445,320	\$ 2,474	1
2	5	Utilities	Management Fee Income 6,616,778	19	37,212		445,320	2,504	2
3	6	Maintenance - Other	Management Fee Income 6,616,778	19	16,939		445,320	1,140	3
4	11	Activities-Special Events	Management Fee Income 6,616,778	19	7,482		445,320	504	4
5	17	Admin - Misc. Other	Management Fee Income 6,616,778	19	(20,102)		445,320	(1,353)	5
6	17	Administrative Salaries	Management Fee Income 6,616,778	19	2,433,377	2,433,377	445,320	163,770	6
7	19	Professional Services	Management Fee Income 6,616,778	19	391,693		445,320	26,362	7
8	20	Dues,Subscriptions	Management Fee Income 6,616,778	19	93,352		445,320	6,283	8
9	21	Clerical Supplies	Management Fee Income 6,616,778	19	108,789		445,320	7,322	9
10	22	Employee Benefits	Management Fee Income 6,616,778	19	697,316		445,320	46,931	10
11	23	Education/Conference	Management Fee Income 6,616,778	19	39,879		445,320	2,684	11
12	24	Travel	Management Fee Income 6,616,778	19	81,549		445,320	5,488	12
13	26	Insurance	Management Fee Income 6,616,778	19	5,664		445,320	381	13
14	30	Depreciation	Management Fee Income 6,616,778	19	36,741		445,320	2,473	14
15	32	Interest	Management Fee Income 6,616,778	19	3,185,539		445,320	214,392	15
16	34	Rent - Facility	Management Fee Income 6,616,778	19	251,434		445,320	16,922	16
17	35	Rent - Equipment	Management Fee Income 6,616,778	19	37,982		445,320	2,556	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 7,441,612	\$ 2,433,377		\$ 500,833	25

Facility Name & ID Number Provena Our Lady of Victory

0041723

Report Period Beginning: 01/01/08

Ending: 12/31/08

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	1,391,394	9	\$ 867,070	\$ 867,070	92,880	\$ 57,880	1
2	22	Employee Benefits	Operating Expense	1,391,394	9	659,854		92,880	44,047	2
3	30	Depreciation	Operating Expense	1,391,394	9	927,633		92,880	61,922	3
4	34	Rent Facility	Operating Expense	1,391,394	9	192,975		92,880	12,882	4
5	19	Admin Consulting,Other	Operating Expense	1,391,394	9	1,505,183		92,880	100,476	5
6	17	Information Systems Salaries	Operating Expense	2,155,920	9	399,935	399,935	144,360	26,780	6
7	22	Information Systems Benefits	Operating Expense	2,155,920	9	203,956		144,360	13,657	7
8	17	Information Systems - Other	Operating Expense	2,155,920	9	279,796		144,360	18,735	8
9	17	Admin Salaries	Direct Cost	1,391,394	9	440,776	440,776	92,880	29,423	9
10	17	Information Systems Salaries	Direct Cost	2,155,920	9	409,925	409,925	144,360	27,449	10
11	6	Information Systems - Equip Main	Direct Cost	2,155,920	9	367,627		144,360	24,616	11
12	19	Admin Consulting,Other	Direct Cost	1,391,394	9	349,224		92,880	23,312	12
13	32	Admin - Interest Expense	Direct Cost	1,391,394	9	5,051,741		92,880	337,220	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					\$ 11,655,695	\$ 2,117,706		\$ 778,399	25

Facility Name & ID Number Provena Our Lady of Victory

0041723

Report Period Beginning: 01/01/08

Ending: 12/31/08

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		\$	\$		551,655	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				\$	\$		551,655	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			
A. Directly Facility Related																				
Long-Term																				
1	Home Office Allocation									\$ 214,392	1									
2											2									
3											3									
4											4									
5											5									
Working Capital																				
6											6									
7											7									
8											8									
9	TOTAL Facility Related					\$	\$			\$ 214,392	9									
B. Non-Facility Related*																				
10											10									
11											11									
12											12									
13											13									
14	TOTAL Non-Facility Related					\$	\$			\$	14									
15	TOTALS (line 9+line14)					\$	\$			\$ 214,392	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:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

2007 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 2007 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 2007.

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

B. Real Estate Tax Cost Allocations

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

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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:

01/01/08 Ending:

12/31/08

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).

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	TOTALS			\$ 135,000	3

Facility Name & ID Number Provena Our Lady of Victory

0041723

Report Period Beginning:

01/01/08

Ending:

12/31/08

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		726,529	5
6	9			1987	33,355		15			33,355	6
7	10			1995	2,520,706	64,282	35	64,282		858,189	7
8											8
Improvement Type**											
9	Various			1982	95,473		25			95,473	9
10	Various			1985	300		15			300	10
11	Various			1986	45,673		21			45,673	11
12	Various			1987	14,973	361	21	361		14,973	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		9,720	17
18	Various			1994	3,258		8			3,258	18
19	Various			1995	8,996		5			8,996	19
20	Various			1996	192,299	9,388	11	9,388		132,765	20
21	Various			1997	104,421		5			104,421	21
22	Various			1998	48,287		5			48,287	22
23	Various			1999	74,075	3,186	6	3,186		61,688	23
24	Various			2000	25,153	1,401	7	1,401		23,051	24
25	Various			2001	107,190	8,159	6	8,159		86,793	25
26	Various			2002	67,798	6,099	8	6,099		47,356	26
27	Various			2003	175,875	13,789	10	13,789		75,926	27
28	Various			2004	223,544	18,863	10	18,863		78,102	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:

01/01/08

Ending:

12/31/08

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	CARPET-ENTRANCE,LOBBY,C&	2005	\$ 43,622	\$ 8,724	5	\$ 8,724	\$	\$ 34,898	37
38	LANDSCAPING	2005	13,000	1,300	10	1,300		4,550	38
39	INSTALL A/C IN ACTIVITY	2005	11,500	1,150	10	1,150		4,600	39
40	REPAVING OF PARKING LOT	2005	10,996	1,375	8	1,375		4,811	40
41	KM SYSTEMS 2100 & 3100 S	2005	8,119	812	10	812		2,842	41
42	CONNECT 2 FURNACES TO EM	2005	7,952	795	10	795		2,783	42
43	INSTALLATION OF EMERGENC	2005	6,996	1,399	5	1,399		4,897	43
44	ELECTRICAL - 110 V WIRIN	2005	2,841	142	20	142		497	44
45	(6) 120V RECEPTICLES FOR	2005	2,600	260	10	260		910	45
46	STEELCRAFT ENTRANCE PAK	2005	2,215	222	10	222		775	46
47	SIGN ON CORNER AND RELOC	2005	1,972	197	10	197		690	47
48	AIR COMPRESSOR FOR SPRIN	2005	1,855	124	15	124		495	48
49	MOVE SIGN TO CORNER	2005	1,500	300	5	300		1,050	49
50	TREE & STUMP REMOVAL	2005	1,500	300	5	300		1,050	50
51	PHONE SYSTEM EXPANSION	2005	991	66	15	66		231	51
52	(2) STEELCRAFT WINDOWS	2005	761	152	5	152		533	52
53	INSTALL THREE APMPERAGE	2005	740	106	7	106		423	53
54	SPRINKLER PROJECT	2005	45	9	5	9		36	54
55									55
56	SIDEWALKS	2006	13,687	912	15	912		2,281	56
57	FIX DAMAGED CEILING	2006	12,750	2,550	5	2,550		6,375	57
58	RESAEALING AND STRIPING	2006	9,659	966	10	966		2,415	58
59	CLOSET DOORS	2006	5,667	378	15	378		945	59
60	REPAVE PARKING LOT	2006	5,248	656	8	656		1,968	60
61	PATCH/PAINT FRONT ENTRAN	2006	3,300	660	5	660		1,650	61
62	NEW HOLLOW METAL DOOR	2006	1,984	99	20	99		248	62
63	PLATE WARMERS IN KITCHEN	2006	1,834	183	10	183		458	63
64	POUR AND FINISH CONCRETE	2006	1,471	98	15	98		245	64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 5,281,323	\$ 179,150		\$ 179,150	\$	\$ 3,163,538	70

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

Facility Name & ID Number Provena Our Lady of Victory

0041723

Report Period Beginning:

01/01/08

Ending:

12/31/08

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 5,281,323	\$ 179,150		\$ 179,150	\$	\$ 3,163,538	1
2									2
3	PANELFORD FOLDING PARTIT	2007	13,206	1,321	10	1,321		1,981	3
4	WATER HEATER REPAIRS	2007	5,250	525	10	525		1,050	4
5	PATCH/PAINT CAFETERIA, GENTELMAN ROOM	2007	4,919	984	5	984		1,476	5
6									6
7	ROOF REPLACEMENT	2008	61,262	3,063	10	6,126	3,063	3,063	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	TOTAL (lines 1 thru 33)		\$ 5,365,960	\$ 185,042		\$ 188,105	\$ 3,063	\$ 3,171,107	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: 01/01/08 Ending: 12/31/08

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	\$ 435,025	\$ 45,952	\$ 45,952	\$	9	\$ 154,718	71
72	Current Year Purchases	90,439	5,533	11,066	5,533	10	5,738	72
73	Fully Depreciated Assets	332,619				6	332,069	73
74	Home Office Allocation		64,395	64,395				74
75	TOTALS	\$ 858,083	\$ 115,880	\$ 121,413	\$ 5,533		\$ 492,525	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	\$	\$	\$	8	\$ 44,910	76
77										77
78										78
79										79
80	TOTALS			\$ 44,910	\$	\$	\$		\$ 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)	\$ 6,403,952	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 300,922	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 309,518	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 8,596	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,708,543	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				16,922			5
6					_____			6
7	TOTAL				\$ 16,922			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.	_____ /2009	\$ _____
13.	_____ /2010	\$ _____
14.	_____ /2011	\$ _____

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: \$ 36,209 Description: Nursing \$25,830; Administration \$7,823; Home Office \$2,556

(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?</p> <p><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. CLASSROOM PORTION:</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. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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	\$	5,181	\$ 320,881	\$	5,181	\$ 320,881	1
2	Licensed Speech and Language Development Therapist	10a,3	hrs		1,473	92,176		1,473	92,176	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a,3	hrs		5,698	351,110		5,698	351,110	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39,3	# of prescrpts				551,655		551,655	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$	12,352	\$ 764,167	\$ 551,655	12,352	\$ 1,315,822	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: 01/01/08

Ending:

12/31/08

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/08

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 7,556,064	\$	1
2	Cash-Patient Deposits	112,800		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	14,518,279		3
4	Supply Inventory (priced at)	609,759		4
5	Short-Term Investments			5
6	Prepaid Insurance	22,320		6
7	Other Prepaid Expenses	150,561		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 22,969,783	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	6,624,013		12
13	Land	6,742,855		13
14	Buildings, at Historical Cost	84,767,866		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	18,707,364		16
17	Accumulated Depreciation (book methods)	(52,758,206)		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>	113,256		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 64,197,148	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 87,166,931	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 4,366,203	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,621,117		28
29	Short-Term Notes Payable	50,318		29
30	Accrued Salaries Payable	3,252,222		30
31	Accrued Taxes Payable (excluding real estate taxes)	103,086		31
32	Accrued Real Estate Taxes(Sch.IX-B)	935,960		32
33	Accrued Interest Payable	29,590		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Due to Related Party</u>	1,231,737		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 11,590,233	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,218,868		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	289,981		42
	Other Long-Term Liabilities(specify):			
43	<u>Conditional Asset Retirement</u>	438,744		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,947,593	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 13,537,826	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 73,629,105	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 87,166,931	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 73,253,756	1
2	Restatements (describe):		2
3	Transfer to Affiliates	(358,099)	3
4	Adj. To reconcile consolidated equity & consolidated income	135,452	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 73,031,109	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	158,583	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	683,319	11
12	Expenditures for Specific Purposes	(243,906)	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)	\$ 597,996	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 73,629,105	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Provena Our Lady of Victory# 0041723Report Period Beginning: 01/01/08Ending: 12/31/08**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 5,249,605	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,249,605	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,158,211	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,158,211	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	7,309	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	500,632	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 507,941	23
D. Non-Operating Revenue			
24	Contributions	70,514	24
25	Interest and Other Investment Income***	2,523	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 73,037	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Purchase Rebates	268,373	28
28a	Misc. Income, Gain/Loss SOFA	8,833	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 277,206	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,266,000	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,080,110	31
32	Health Care	3,341,220	32
33	General Administration	1,830,816	33
B. Capital Expense			
34	Ownership	244,873	34
C. Ancillary Expense			
35	Special Cost Centers	551,655	35
36	Provider Participation Fee	58,743	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,107,417	40
41	Income before Income Taxes (line 30 minus line 40)**	158,583	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 158,583	43

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

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

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

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

Facility Name & ID Number Provena Our Lady of Victory

0041723

Report Period Beginning: 01/01/08

Ending:

12/31/08

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	2,088	2,144	\$ 95,993	\$ 44.77	1
2	Assistant Director of Nursing	1,335	1,367	41,400	30.29	2
3	Registered Nurses	18,270	19,809	568,085	28.68	3
4	Licensed Practical Nurses	30,522	32,352	664,191	20.53	4
5	CNAs & Orderlies	54,555	57,676	676,847	11.74	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,944	8,678	103,320	11.91	8
9	Activity Director	1,860	2,080	32,776	15.76	9
10	Activity Assistants	3,197	3,332	25,991	7.80	10
11	Social Service Workers	3,730	4,158	54,947	13.21	11
12	Dietician	1,940	2,080	46,858	22.53	12
13	Food Service Supervisor	1,790	1,956	22,950	11.73	13
14	Head Cook	1,796	2,012	21,921	10.90	14
15	Cook Helpers/Assistants	16,241	17,428	147,182	8.45	15
16	Dishwashers					16
17	Maintenance Workers	5,050	5,377	83,762	15.58	17
18	Housekeepers	19,140	20,725	197,665	9.54	18
19	Laundry	1,935	2,127	21,589	10.15	19
20	Administrator	752	776	40,155	51.75	20
21	Assistant Administrator	376	424	14,083	33.21	21
22	Other Administrative	6,945	7,309	131,676	18.02	22
23	Office Manager					23
24	Clerical	4,430	4,862	42,191	8.68	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</u>	1,960	2,080	34,702	16.68	33
34	TOTAL (lines 1 - 33)	185,856	198,752	\$ 3,068,284 *	\$ 15.44	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	241	\$ 19,433	1,3	35
36	Medical Director	\$600/mo	6,600	9,3	36
37	Medical Records Consultant	24	1,715	10,3	37
38	Nurse Consultant	7	1,306	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	4	75	11,3	44
45	Social Service Consultant	20	1,185	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	296	\$ 30,314		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses			50	
51	Licensed Practical Nurses			51	
52	Certified Nurse Assistants/Aides	3,768	86,292	10a,3	52
53	TOTAL (lines 50 - 52)	3,768	\$ 86,292		53

Facility Name & ID Number Provena Our Lady of Victory

0041723

Report Period Beginning: 01/01/08

Ending: 12/31/08

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Robin Gifford	Administrator	0	\$ 31,580	Workers' Compensation Insurance	\$ 84,960	IDPH License Fee	\$	
Administrative Staff	Admissions	0	44,341	Unemployment Compensation Insurance	8,396	Advertising: Employee Recruitment		
Administrative Staff	Human Resources	0	39,411	FICA Taxes	217,467	Health Care Worker Background Check		
Administrative Staff	Bookkeeper	0	31,930	Employee Health Insurance	283,654	(Indicate # of checks performed <u>82</u>)		
Administrative Staff	Receptionist	0	42,191	Employee Meals		Patient Background Checks <u>132</u>		
Administrative Staff	Asst Administrator	0	14,086	Illinois Municipal Retirement Fund (IMRF)*		Employee Recruitment	6,907	
Melissa Adams/Betty Hillier	Intern Administrator	0	24,567	Life Insurance	13,839	Dues & Subscriptions	10,304	
TOTAL (agree to Schedule V, line 17, col. 1)				Pension	86,012	Advertising & Public Relations	8,108	
(List each licensed administrator separately.)			\$ 228,106	Employee Recognition	849			
B. Administrative - Other				Executive Benefits	290	Home Office Allocation	6,283	
Description			Amount	Employment Screenings	16,808	Less: Public Relations Expense	()	
Corporate Service Fee			\$ 92,880	Home Office Allocation	171,797	Non-allowable advertising	(6,362)	
Corporate IS Fee			144,360			Yellow page advertising	()	
Mgmt Fee			288,840	TOTAL (agree to Schedule V, line 22, col.8)			\$ 884,072	
Mgmt Fee Interest			156,480	E. Schedule of Non-Cash Compensation Paid to Owners or Employees				
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 682,560	Description			Amount	
(Attach a copy of any management service agreement)				Line #				
C. Professional Services				G. Schedule of Travel and Seminar**				
Vendor/Payee	Type		Amount	Description			Amount	
Legal Expense	Various		\$ 575	Out-of-State Travel			\$	
Survey & Analytical Tools	Various		722					
Shredding	Various		1,640					
Monitoring Service	Various		856	In-State Travel			17,158	
Outsourced Services	Various		943					
Living Design	Various		968					
Surety Bond	Various		500	Seminar Expense				
Care Counselor	Various		772					
TOTAL (agree to Schedule V, line 19, column 3)				Home Office Allocation			5,488	
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 6,976	Entertainment Expense			()	
				(agree to Sch. V, line 24, col. 8)				
				TOTAL			\$ 22,646	

* Attach copy of IMRF notifications

**See instructions.

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 \$5050
- (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. \$ 37,726 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 58,743
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? No Indicate the amount. \$ None
- (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.