



Facility Name & ID Number Provena Our Lady of Victory

# 0041723 Report Period Beginning: 01/01/09 Ending: 12/31/09

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 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	4 Private Pay	Other	Total	
8	SNF	23,104	2,785	8,386	34,275	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	23,104	2,785	8,386	34,275	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.76%

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 7,906

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/09 Fiscal Year: 12/31/09

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

Facility Name & ID Number Provena Our Lady of Victory # 0041723 Report Period Beginning: 01/01/09 Ending: 12/31/09

**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	288,915	43,819	26,938	359,672		359,672		359,672		1
2	Food Purchase		195,329		195,329		195,329	115	195,444		2
3	Housekeeping	177,840	15,089	8	192,937		192,937		192,937		3
4	Laundry	22,082	8,219		30,301		30,301		30,301		4
5	Heat and Other Utilities			121,804	121,804		121,804	2,529	124,333		5
6	Maintenance	96,774	11,281	56,210	164,265		164,265	38,409	202,674		6
7	Other (specify):*	36,532	48	19,326	55,906		55,906	(19,310)	36,596		7
8	<b>TOTAL General Services</b>	622,143	273,785	224,286	1,120,214		1,120,214	21,743	1,141,957		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	2,160,654	192,946	90,774	2,444,374		2,444,374		2,444,374		10
10a	Therapy			819,285	819,285		819,285		819,285		10a
11	Activities	66,845	1,091	8,488	76,424		76,424	204	76,628		11
12	Social Services	59,617		488	60,105		60,105		60,105		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	2,287,116	194,037	926,235	3,407,388		3,407,388	204	3,407,592		16
	<b>C. General Administration</b>										
17	Administrative	256,432	8,317	670,721	935,470		935,470	(284,666)	650,804		17
18	Directors Fees										18
19	Professional Services			13,385	13,385		13,385	44,878	58,263		19
20	Dues, Fees, Subscriptions & Promotions			23,736	23,736		23,736	1,802	25,538		20
21	Clerical & General Office Expenses			63,822	63,822		63,822	(31,901)	31,921		21
22	Employee Benefits & Payroll Taxes			786,226	786,226		786,226	212,858	999,084		22
23	Inservice Training & Education			2,190	2,190		2,190	2,213	4,403		23
24	Travel and Seminar			2,798	2,798		2,798	3,900	6,698		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			81,752	81,752		81,752	(55)	81,697		26
27	Other (specify):* <b>Bad Debt</b>			(48,754)	(48,754)		(48,754)	48,754			27
28	<b>TOTAL General Administration</b>	256,432	8,317	1,595,876	1,860,625		1,860,625	(2,217)	1,858,408		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	3,165,691	476,139	2,746,397	6,388,227		6,388,227	19,730	6,407,957		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:

01/01/09

Ending:

12/31/09

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			212,667	212,667		212,667	61,612	274,279			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							297,516	297,516			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds							19,729	19,729			34
35	Rent-Equipment & Vehicles			10,296	10,296		10,296	2,458	12,754			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			222,963	222,963		222,963	381,315	604,278			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			538,321	538,321		538,321	(303,269)	235,052			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			58,583	58,583		58,583		58,583			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			596,904	596,904		596,904	(303,269)	293,635			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,165,691	476,139	3,566,264	7,208,094		7,208,094	97,776	7,305,870			45

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



Provena Our Lady of Victory

ID# 0041723

Report Period Beginning: 01/01/09

Ending: 12/31/09

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Office Supplies	\$ (24)	7	1
2	Postage/Mail/Courier	(13)	7	2
3	Other Purchased Serv.	(1,247)	7	3
4	Development Misc	(18,026)	7	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(19,310)		49

## STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

01/01/09

Ending:

12/31/09

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,793)	1,908	0	0	0	0	0	0	0	0	0	115	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	2,529	0	0	0	0	0	0	0	0	0	2,529	5
6	Maintenance	0	681	37,728	0	0	0	0	0	0	0	0	38,409	6
7	Other (specify):*	(19,310)	0	0	0	0	0	0	0	0	0	0	(19,310)	7
8	<b>TOTAL General Services</b>	<b>(21,103)</b>	<b>5,118</b>	<b>37,728</b>	<b>0</b>	<b>21,743</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	204	0	0	0	0	0	0	0	0	0	204	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>204</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>204</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	(270,554)	(14,112)	0	0	0	0	0	0	0	0	(284,666)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	28,783	16,095	0	0	0	0	0	0	0	0	44,878	19
20	Fees, Subscriptions & Promotions	(3,282)	5,084	0	0	0	0	0	0	0	0	0	1,802	20
21	Clerical & General Office Expenses	(37,830)	5,929	0	0	0	0	0	0	0	0	0	(31,901)	21
22	Employee Benefits & Payroll Taxes	0	78,872	133,986	0	0	0	0	0	0	0	0	212,858	22
23	Inservice Training & Education	0	2,213	0	0	0	0	0	0	0	0	0	2,213	23
24	Travel and Seminar	0	3,900	0	0	0	0	0	0	0	0	0	3,900	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	(55)	0	0	0	0	0	0	0	0	0	(55)	26
27	Other (specify):*	48,754	0	0	0	0	0	0	0	0	0	0	48,754	27
28	<b>TOTAL General Administration</b>	<b>7,642</b>	<b>(145,828)</b>	<b>135,969</b>	<b>0</b>	<b>(2,217)</b>	<b>28</b>							
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(13,461)</b>	<b>(140,506)</b>	<b>173,697</b>	<b>0</b>	<b>19,730</b>	<b>29</b>							

## STATE OF ILLINOIS

Summary B

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

Report Period Beginning:

01/01/09

Ending:

12/31/09

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
30	Depreciation	4,993	0	56,619	0	0	0	0	0	0	0	0	61,612	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(9,789)	0	307,305	0	0	0	0	0	0	0	0	297,516	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	19,729	0	0	0	0	0	0	0	0	19,729	34
35	Rent-Equipment & Vehicles	0	0	2,458	0	0	0	0	0	0	0	0	2,458	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(4,796)</b>	<b>0</b>	<b>386,111</b>	<b>0</b>	<b>381,315</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	(303,269)	0	0	0	0	0	0	0	0	0	0	(303,269)	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>(303,269)</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>(303,269)</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(321,526)</b>	<b>(140,506)</b>	<b>559,808</b>	<b>0</b>	<b>97,776</b>	<b>45</b>							

**VII. RELATED PARTIES**

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	2 Food	\$	Provena Senior Services	100.00%	\$ 1,908	\$ 1,908	1
2	V	5 Utilities		Provena Senior Services	100.00%	2,529	2,529	2
3	V	6 Maintenance - Other		Provena Senior Services	100.00%	681	681	3
4	V	11 Activities-Special Events		Provena Senior Services	100.00%	204	204	4
5	V	17 Admin - Misc. Other		Provena Senior Services	100.00%	5,225	5,225	5
6	V	17 Administrative Salaries	457,176	Provena Senior Services	100.00%	181,397	(275,779)	6
7	V	19 Professional Services		Provena Senior Services	100.00%	28,783	28,783	7
8	V	20 Dues,Subscriptions		Provena Senior Services	100.00%	5,084	5,084	8
9	V	21 Clerical Supplies		Provena Senior Services	100.00%	5,929	5,929	9
10	V	22 Employee Benefits		Provena Senior Services	100.00%	78,872	78,872	10
11	V	23 Education/Conference		Provena Senior Services	100.00%	2,213	2,213	11
12	V	24 Travel		Provena Senior Services	100.00%	3,900	3,900	12
13	V	26 Insurance		Provena Senior Services	100.00%	(55)	(55)	13
14	Total		\$ 457,176			\$ 316,670	\$ * (140,506)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	30 Depreciation	\$	Provena Senior Services	100.00%	\$ 2,543	\$ 2,543
16	V	32 Interest		Provena Senior Services	100.00%	154,364	154,364
17	V	34 Rent - Facility		Provena Senior Services	100.00%	19,729	19,729
18	V	35 Rent - Equipment		Provena Senior Services	100.00%	2,458	2,458
19	V	17 Admin Salaries	85,308	Provena Health Services	100.00%	71,484	(13,824)
20	V	22 Employee Benefits		Provena Health Services	100.00%	45,684	45,684
21	V	30 Depreciation		Provena Health Services	100.00%	54,076	54,076
22	V	19 Admin Consulting, Other		Provena Health Services	100.00%	16,095	16,095
23	V	17 Information Systems Salaries	128,237	Provena Health Services	100.00%	68,073	(60,164)
24	V	22 Information Systems Benefits		Provena Health Services	100.00%	25,397	25,397
25	V	17 Information Systems - Other		Provena Health Services	100.00%	21,820	21,820
26	V	17 Admin Salaries		Provena Health Services	100.00%	9,872	9,872
27	V	22 Employee Benefits		Provena Health Services	100.00%	40,697	40,697
28	V	17 Information Systems Salaries		Provena Health Services	100.00%	28,184	28,184
29	V	22 Information Systems Benefits		Provena Health Services	100.00%	22,208	22,208
30	V	6 Information Systems - Equip Maint		Provena Health Services	100.00%	37,728	37,728
31	V	32 Admin - Interest Expense		Provena Health Services	100.00%	152,941	152,941
32	V	39 Ancillary Services - Other	538,321	Provena Senior Services Pharmacy	100.00%	538,321	
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 751,866			\$ 1,311,674	\$ * 559,808

\* 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: 01/01/09 Ending: 12/31/09

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:

01/01/09

Ending: 12/31/09

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	6,810,879	19	\$ 28,423	\$ 457,176	\$ 1,908	1
2	5	Utilities	Management Fee Income	6,810,879	19	37,672	457,176	2,529	2
3	6	Maintenance - Other	Management Fee Income	6,810,879	19	10,148	457,176	681	3
4	11	Activities-Special Events	Management Fee Income	6,810,879	19	3,032	457,176	204	4
5	17	Admin - Misc. Other	Management Fee Income	6,810,879	19	77,835	457,176	5,225	5
6	17	Administrative Salaries	Management Fee Income	6,810,879	19	2,702,403	2,702,403	181,397	6
7	19	Professional Services	Management Fee Income	6,810,879	19	428,802	457,176	28,783	7
8	20	Dues,Subscriptions	Management Fee Income	6,810,879	19	75,736	457,176	5,084	8
9	21	Clerical Supplies	Management Fee Income	6,810,879	19	88,333	457,176	5,929	9
10	22	Employee Benefits	Management Fee Income	6,810,879	19	1,175,007	457,176	78,872	10
11	23	Education/Conference	Management Fee Income	6,810,879	19	32,966	457,176	2,213	11
12	24	Travel	Management Fee Income	6,810,879	19	58,096	457,176	3,900	12
13	26	Insurance	Management Fee Income	6,810,879	19	(818)	457,176	(55)	13
14	30	Depreciation	Management Fee Income	6,810,879	19	37,881	457,176	2,543	14
15	32	Interest	Management Fee Income	6,810,879	19	2,299,667	457,176	154,364	15
16	34	Rent - Facility	Management Fee Income	6,810,879	19	293,923	457,176	19,729	16
17	35	Rent - Equipment	Management Fee Income	6,810,879	19	36,626	457,176	2,458	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 7,385,732	\$ 2,702,403	\$ 495,764	25

Facility Name & ID Number Provena Our Lady of Victory

# 0041723

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	17	Admin Salaries	Operating Expense	1,290,832	9	\$ 1,081,653	\$ 1,081,653	85,308	\$ 71,484	1
2	22	Employee Benefits	Operating Expense	1,290,832	9	691,262		85,308	45,684	2
3	30	Depreciation	Operating Expense	1,290,832	9	818,246		85,308	54,076	3
4	34	Rent Facility	Operating Expense	1,290,832	9	243,546		85,308	16,095	4
5	19	Admin Consulting,Other	Operating Expense	1,290,832	9	1,030,040		85,308	68,073	5
6	17	Information Systems Salaries	Operating Expense	1,941,141	9	384,433	384,433	128,237	25,397	6
7	22	Information Systems Benefits	Operating Expense	1,941,141	9	330,293		128,237	21,820	7
8	17	Information Systems - Other	Operating Expense	1,941,141	9	149,433		128,237	9,872	8
9	17	Admin Salaries	Direct Cost	1,290,832	9	615,798	615,798	85,308	40,697	9
10	17	Information Systems Salaries	Direct Cost	1,941,141	9	426,627	426,627	128,237	28,184	10
11	6	Information Systems - Equip Maint	Direct Cost	1,941,141	9	336,162		128,237	22,208	11
12	19	Admin Consulting,Other	Direct Cost	1,290,832	9	570,873		85,308	37,728	12
13	32	Admin - Interest Expense	Direct Cost	1,290,832	9	2,314,209		85,308	152,941	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					\$ 8,992,575	\$ 2,508,511		\$ 594,259	25

Facility Name & ID Number Provena Our Lady of Victory

# 0041723

Report Period Beginning:

01/01/09

Ending: 12/31/09

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		\$	\$		\$ 538,321	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				\$	\$		\$ 538,321	25

Facility Name & ID Number

Provena Our Lady of Victory

# 0041723

Report Period Beginning:

01/01/09

Ending:

12/31/09

**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		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					\$	\$			\$ 154,364	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>					\$	\$			\$ 154,364	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>					\$	\$			\$ 154,364	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.)





Facility Name & ID Number Provena Our Lady of Victory

# 0041723

Report Period Beginning:

01/01/09

Ending:

12/31/09

**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:**

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Nursing Home</u>		<u>1981</u>	<u>\$ 135,000</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>			<b>\$ 135,000</b>	<b>3</b>

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	80		1981	\$ 507,112	\$	25	\$	\$	\$ 507,112	4
5	8		1984	726,964	435	25	435		726,964	5
6	9		1987	33,355		15			33,355	6
7	10		1995	2,520,706	64,282	35	64,282		922,471	7
8										8
<b>Improvement Type**</b>										
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		21			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		10,328	17
18	Various		1994	3,258		8			3,258	18
19	Various		1995	8,996		5			8,996	19
20	Various		1996	95,992	4,653	11	4,653		72,416	20
21	Various		1997	200,728	4,735	5	4,735		174,159	21
22	Various		1998	48,287		5			48,287	22
23	Various		1999	74,075	2,672	6	2,672		64,360	23
24	Various		2000	25,153	1,401	7	1,401		24,452	24
25	Various		2001	107,190	8,159	6	8,159		94,952	25
26	Various		2002	72,508	6,099	8	6,099		58,165	26
27	Various		2003	174,814	13,850	10	13,850		86,890	27
28	Various		2004	277,657	25,007	10	25,007		141,736	28
29	Various		2005	66,692	9,367	10	9,367		35,563	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

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	SIDEWALKS	2006	\$ 13,687	\$ 912	15	\$ 912	\$	\$ 3,194	37
38	FIX DAMAGED CEILING	2006	12,750	2,550	5	2,550		8,925	38
39	RESAEALING AND STRIPING	2006	9,659	966	10	966		3,381	39
40	CLOSET DOORS	2006	5,667	378	15	378		1,322	40
41	WATER HEATER REPAIRS	2006	5,250	525	10	525		1,575	41
42	PATCH/PAINT FRONT ENTRAN	2006	3,300	660	5	660		2,310	42
43	NEW HOLLOW METAL DOOR	2006	1,984	99	20	99		347	43
44	PLATE WARMERS IN KITCHEN	2006	1,834	183	10	183		642	44
45	POUR AND FINISH CONCRETE	2006	1,471	98	15	98		343	45
46									46
47	PANELFORD FOLDING PARTIT	2007	13,206	1,321	10	1,321		3,301	47
48	PATCH/PAINT CAFETERIA, GENTELMAN ROOM	2007	4,919	984	5	984		2,460	48
49									49
50									50
51	ROOF REPLACEMENT	2008	61,262	6,126	10	6,126		9,189	51
52									52
53	ROOF AND DECK REPLACEMENT	2009	63,025	3,151	10	6,303	3,151	3,151	53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 5,428,984	\$ 159,220		\$ 162,372	\$ 3,151	\$ 3,328,936	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:

01/01/09

Ending:

12/31/09

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	\$ 514,287	\$ 51,604	\$ 51,604	\$	9	\$ 197,887	71
72	Current Year Purchases	30,521	1,842	3,684	1,842	10	1,842	72
73	Fully Depreciated Assets	336,050				6	335,499	73
74	Home Office Allocation		56,619	56,619				74
75	TOTALS	\$ 880,858	\$ 110,065	\$ 111,907	\$ 1,842		\$ 535,228	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)	\$ 6,489,752	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 269,285	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 274,279	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 4,993	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,909,075	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				19,729			5
6								6
7	TOTAL				\$ 19,729			7

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

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

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_\*

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

15. Is Movable equipment rental included in building rental? \_\_\_\_\_

YES  NO

16. Rental Amount for movable equipment: \$ 38,182 Description: Nursing \$25,567; Administration \$10,157; Home Office \$2,458

(Attach a schedule detailing the breakdown of movable equipment)

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

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

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending Annual Rent

12. \_\_\_\_\_/2010 \$ \_\_\_\_\_

13. \_\_\_\_\_/2011 \$ \_\_\_\_\_

14. \_\_\_\_\_/2012 \$ \_\_\_\_\_

\* 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>
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**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	10a,3	hrs	\$	5,320	\$ 339,651	\$	5,320	\$ 339,651	1	
2	Licensed Speech and Language Development Therapist	10a,3	hrs		1,385	89,160		1,385	89,160	2	
3	Licensed Recreational Therapist		hrs							3	
4	Licensed Physical Therapist	10a,3	hrs		6,102	390,474		6,102	390,474	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				540,097		540,097	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	<b>TOTAL</b>			\$	12,807	\$ 819,285	\$ 540,097	12,807	\$ 1,359,382	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.

**XV. BALANCE SHEET - Unrestricted Operating Fund.**

As of **12/31/09**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 12,337,938	\$	1
2	Cash-Patient Deposits	107,856		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	12,517,618		3
4	Supply Inventory (priced at )	682,337		4
5	Short-Term Investments			5
6	Prepaid Insurance	21,512		6
7	Other Prepaid Expenses	152,000		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>	\$ 25,819,261	\$	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments	7,398,236		12
13	Land	6,820,469		13
14	Buildings, at Historical Cost	85,287,605		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	18,957,385		16
17	Accumulated Depreciation (book methods)	(56,011,567)		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>	106,392		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 62,558,520	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 88,377,781	\$	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 5,373,551	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,366,224		28
29	Short-Term Notes Payable	52,481		29
30	Accrued Salaries Payable	3,681,842		30
31	Accrued Taxes Payable (excluding real estate taxes)	113,556		31
32	Accrued Real Estate Taxes(Sch.IX-B)	1,098,515		32
33	Accrued Interest Payable	17,377		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>	913,853		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 12,617,399	\$	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable	1,170,110		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	382,071		42
<b>Other Long-Term Liabilities(specify):</b>				
43	<u>Conditional Asset Retirement</u>	438,744		43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 1,990,925	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 14,608,324	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 73,769,457	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 88,377,781	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b>	
		<b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>73,629,105</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Transfer to Affiliates</b>	<b>(5,368,199)</b>	<b>3</b>
<b>4</b>	<b>Adj. To reconcile consolidated equity &amp; consolidated income</b>	<b>4,364,114</b>	<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>72,625,020</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>447,010</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants	<b>857,343</b>	<b>11</b>
<b>12</b>	Expenditures for Specific Purposes	<b>(159,916)</b>	<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>1,144,437</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>73,769,457</b>	<b>24</b> *

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

Facility Name & ID Number Provena Our Lady of Victory# 0041723Report Period Beginning: 01/01/09Ending: 12/31/09

**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	\$ 5,488,267	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 5,488,267	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,282,075	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 1,282,075	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	5,206	12
13	Barber and Beauty Care	923	13
14	Non-Patient Meals	1,793	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	481,469	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>	\$ 489,391	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	70,566	24
25	Interest and Other Investment Income***	9,789	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 80,355	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Purchase Rebates</u>	303,269	28
28a	<u>Misc Income &amp; Gain/Loss SOFA</u>	11,747	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 315,016	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 7,655,104	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,120,214	31
32	Health Care	3,407,388	32
33	General Administration	1,860,625	33
<b>B. Capital Expense</b>			
34	Ownership	222,963	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	538,321	35
36	Provider Participation Fee	58,583	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 7,208,094	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	447,010	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 447,010	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:

**01/01/09**

Ending:

**12/31/09**

**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	1,624	1,712	\$ 73,468	\$ 42.91	1
2	Assistant Director of Nursing	1,655	1,776	59,722	33.63	2
3	Registered Nurses	18,187	19,542	510,092	26.10	3
4	Licensed Practical Nurses	30,247	32,512	658,537	20.26	4
5	CNAs & Orderlies	55,047	58,065	758,549	13.06	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,663	8,448	100,286	11.87	8
9	Activity Director	1,856	2,080	34,140	16.41	9
10	Activity Assistants	3,293	3,497	32,705	9.35	10
11	Social Service Workers	3,916	4,339	59,618	13.74	11
12	Dietician	2,155	2,315	49,855	21.54	12
13	Food Service Supervisor	3,726	4,025	45,129	11.21	13
14	Head Cook					14
15	Cook Helpers/Assistants	20,111	21,295	193,930	9.11	15
16	Dishwashers					16
17	Maintenance Workers	5,647	6,055	96,775	15.98	17
18	Housekeepers	17,535	19,226	177,840	9.25	18
19	Laundry	1,895	2,076	22,082	10.64	19
20	Administrator	1,996	2,080	108,416	52.12	20
21	Assistant Administrator					21
22	Other Administrative	6,587	7,024	106,868	15.21	22
23	Office Manager					23
24	Clerical	4,181	4,633	41,148	8.88	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>	1,968	2,080	36,531	17.56	33
34	TOTAL (lines 1 - 33)	189,289	202,780	\$ 3,165,691 *	\$ 15.61	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	219	\$ 25,440	1,3	35
36	Medical Director	\$600/mo	7,200	9,3	36
37	Medical Records Consultant	40	2,853	10,3	37
38	Nurse Consultant	8	682	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	15	986	11,3	44
45	Social Service Consultant	8	488	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	290	\$ 37,649		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	2,042	46,164	10a,3	52
53	TOTAL (lines 50 - 52)	2,042	\$ 46,164		53

**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	\$ 108,416	Workers' Compensation Insurance	\$ 81,409	IDPH License Fee	\$	
Administrative Staff	Admissions	0	39,525	Unemployment Compensation Insurance	22,623	Advertising: Employee Recruitment		
Administrative Staff	Human Resources	0	34,322	FICA Taxes	227,661	Health Care Worker Background Check		
Administrative Staff	Bookkeeper	0	33,365	Employee Health Insurance	337,132	(Indicate # of checks performed <u>87</u> )		
Administrative Staff	Receptionist	0	40,804	Employee Meals		Patient Background Checks	<u>159</u>	
				Illinois Municipal Retirement Fund (IMRF)*		Employee Recruitment	4,683	
				Life Insurance	13,267	Dues & Subscriptions	12,597	
				Pension	84,255	Advertising & Public Relations	6,456	
				Employee Recognition	93			
				Executive Benefits	3,686	Home Office Allocation	5,084	
				Employment Screenings	16,100	Less: Public Relations Expense	( )	
				Home Office Allocation	212,858	Non-allowable advertising	(3,282)	
						Yellow page advertising	( 0 )	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 256,432	TOTAL (agree to Schedule V, line 22, col.8)	\$ 999,084	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 25,538	
(List each licensed administrator separately.)								
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Corporate Service Fee			\$ 85,308	N/A		\$	Out-of-State Travel	\$
Corporate IS Fee			128,237					
Mgmt Fee			299,376				In-State Travel	2,798
Mgmt Fee Interest			157,800					
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 670,721				Seminar Expense	
(Attach a copy of any management service agreement)							Home Office Allocation	3,900
C. Professional Services				TOTAL			Entertainment Expense	
Vendor/Payee	Type		Amount				(agree to Sch. V, line 24, col. 8)	
Legal Expense	Various		\$ 2,346	TOTAL		\$		
Survey & Analytical Tools	Various		1,143					
Shredding	Various		1,358					
Outsourced Services	Various		4,259					
Living Design	Various		852					
Care Counselor	Various		3,427					
TOTAL (agree to Schedule V, line 19, column 3)			\$ 13,385					
(If total legal fees exceed \$5,000, attach copy of invoices.)								

\* Attach copy of IMRF notifications

\*\*See instructions.



Facility Name & ID Number Provena Our Lady of Victory# 0041723Report Period Beginning: 01/01/09Ending: 12/31/09**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 \$5,457
- (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. \$ 47,747 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 58,583  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? Yes Indicate the amount. \$ 1,793
- (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
- (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.