FOR BHF USE

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2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

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

I. IDPH License ID Number: 0041723

Facility Name: Provena Our Lady of Victory

Address: 20 Briarcliff Lane (Number) Bourbonnais (City) 60914 (Zip Code)

County: Kankakee

Telephone Number: (815) 937-2022 **Fax #** (815) 936-3231

HFS ID Number:

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

Type of Ownership:

- [x] VOLUNTARY,NON-PROFIT
  - [x] Charitable Corp.
  - [ ] Trust
- [ ] PROPRIETARY
  - [ ] Individual
  - [ ] Partnership
  - [ ] Corporation
  - [ ] "Sub-S" Corp.
  - [ ] Limited Liability Co.
  - [ ] Trust
  - [ ] Other
- [ ] GOVERNMENTAL
  - [ ] State
  - [ ] County
  - [ ] Other

IRS Exemption Code 501 C3

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2011 to 12/31/2011 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Michael R. Gordon
(Title) CFO, VP of Finance

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Provena Our Lady of Victory # 0041723 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 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: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	24,200	3,982	7,434	35,616	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	24,200	3,982	7,434	35,616	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.19%

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 [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

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 [X] Date 11/6/1981 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 55 and days of care provided 7,231

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/11 Fiscal Year: 12/31/11

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

Facility Name & ID Number Provena Our Lady of Victory # 0041723 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	308,963	39,286	9,067	357,316		357,316		357,316			1
2	Food Purchase		239,839		239,839		239,839	(487)	239,352			2
3	Housekeeping	215,598	15,933		231,531		231,531		231,531			3
4	Laundry	4,738	8,855		13,593		13,593		13,593			4
5	Heat and Other Utilities			125,177	125,177		125,177	4,563	129,740			5
6	Maintenance	90,310	7,395	83,018	180,723		180,723	58,204	238,927			6
7	Other (specify):* Pastoral Care	31,728	87	31,365	63,180		63,180	(31,345)	31,835			7
8	TOTAL General Services	651,337	311,395	248,627	1,211,359		1,211,359	30,935	1,242,294			8
	B. Health Care and Programs											
9	Medical Director			9,750	9,750		9,750		9,750			9
10	Nursing and Medical Records	2,341,776	233,813	114,601	2,690,190		2,690,190		2,690,190			10
10a	Therapy			715,763	715,763		715,763		715,763			10a
11	Activities	63,793	711	7,198	71,702		71,702	1,233	72,935			11
12	Social Services	57,368		744	58,112		58,112		58,112			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,462,937	234,524	848,056	3,545,517		3,545,517	1,233	3,546,750			16
	C. General Administration											
17	Administrative	249,215	11,188	690,904	951,307		951,307	(290,893)	660,414			17
18	Directors Fees											18
19	Professional Services			8,283	8,283		8,283	39,705	47,988			19
20	Dues, Fees, Subscriptions & Promotions			11,194	11,194		11,194	4,180	15,374			20
21	Clerical & General Office Expenses			(1,498)	(1,498)		(1,498)	2,910	1,412			21
22	Employee Benefits & Payroll Taxes			857,079	857,079		857,079	160,538	1,017,617			22
23	Inservice Training & Education			25	25		25	2,841	2,866			23
24	Travel and Seminar			837	837		837	3,113	3,950			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			82,670	82,670		82,670	(369)	82,301			26
27	Other (specify):* Bad Debt			30,332	30,332		30,332	(30,332)				27
28	TOTAL General Administration	249,215	11,188	1,679,826	1,940,229		1,940,229	(108,307)	1,831,922			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,363,489	557,107	2,776,509	6,697,105		6,697,105	(76,139)	6,620,966			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: 01/01/2011 Ending: 12/31/2011

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	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			221,755	221,755		221,755	53,903	275,658			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							294,684	294,684			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds							14,286	14,286			34
35	Rent-Equipment & Vehicles			2,964	2,964		2,964	2,291	5,255			35
36	Other (specify):*											36
37	**TOTAL Ownership**			224,719	224,719		224,719	365,164	589,883			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			569,112	569,112		569,112	(276,331)	292,781			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	**TOTAL Special Cost Centers**			627,695	627,695		627,695	(276,331)	351,364			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,363,489	557,107	3,628,923	7,549,519		7,549,519	12,694	7,562,213			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: 01/01/2011 Ending: 12/31/2011

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,687)	2		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	12,772	30		9
10	Interest and Other Investment Income	(14,540)	32		10
11	Discounts, Allowances, Rebates & Refunds	(276,331)	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	(2,145)	21		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	(30,332)	27		24
25	Fund Raising, Advertising and Promotional	(726)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(408)	20		28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (314,397)		$	30

BHF USE ONLY								
48		49		50		51		52	

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

		1 Amount	2 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)	358,436		34
35	Other- Attach Schedule	(31,345)		35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 327,091		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 12,694		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 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

STATE OF ILLINOIS

Provena Our Lady of Victory

ID# 0041723

Report Period Beginning: 01/01/2011

Ending: 12/31/2011

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Development Misc	$ (31,345)	7	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(31,345)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Provena Our Lady of Victory # 0041723 **Report Period Beginning:** 01/01/2011 **Ending:** 12/31/2011

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	(2,687)	2,200	0	0	0	0	0	0	0	0	0	(487)	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	4,563	0	0	0	0	0	0	0	0	0	4,563	5
6	Maintenance	0	1,123	57,081	0	0	0	0	0	0	0	0	58,204	6
7	Other (specify):*	(31,345)	0	0	0	0	0	0	0	0	0	0	(31,345)	7
8	**TOTAL General Services**	(34,032)	7,886	57,081	0	0	0	0	0	0	0	0	30,935	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	1,233	0	0	0	0	0	0	0	0	0	1,233	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	1,233	0	0	0	0	0	0	0	0	0	1,233	16
	C. General Administration													
17	Administrative	0	(244,845)	(46,048)	0	0	0	0	0	0	0	0	(290,893)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	23,627	16,078	0	0	0	0	0	0	0	0	39,705	19
20	Fees, Subscriptions & Promotions	(1,134)	5,314	0	0	0	0	0	0	0	0	0	4,180	20
21	Clerical & General Office Expenses	(2,145)	5,055	0	0	0	0	0	0	0	0	0	2,910	21
22	Employee Benefits & Payroll Taxes	0	51,114	109,424	0	0	0	0	0	0	0	0	160,538	22
23	Inservice Training & Education	0	2,841	0	0	0	0	0	0	0	0	0	2,841	23
24	Travel and Seminar	0	3,113	0	0	0	0	0	0	0	0	0	3,113	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	(369)	0	0	0	0	0	0	0	0	0	(369)	26
27	Other (specify):*	(30,332)	0	0	0	0	0	0	0	0	0	0	(30,332)	27
28	**TOTAL General Administration**	(33,611)	(154,150)	79,454	0	0	0	0	0	0	0	0	(108,307)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(67,643)	(145,031)	136,535	0	0	0	0	0	0	0	0	(76,139)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Provena Our Lady of Victory # 0041723 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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)	
	D. Ownership													
30	Depreciation	12,772	0	41,131	0	0	0	0	0	0	0	0	53,903	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(14,540)	0	309,224	0	0	0	0	0	0	0	0	294,684	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	14,286	0	0	0	0	0	0	0	0	14,286	34
35	Rent-Equipment & Vehicles	0	0	2,291	0	0	0	0	0	0	0	0	2,291	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(1,768)	0	366,932	0	0	0	0	0	0	0	0	365,164	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	(276,331)	0	0	0	0	0	0	0	0	0	0	(276,331)	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**	(276,331)	0	0	0	0	0	0	0	0	0	0	(276,331)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(345,742)	(145,031)	503,467	0	0	0	0	0	0	0	0	12,694	45

Facility Name & ID Number Provena Our Lady of Victory # 0041723 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		Provena Our Lady of Victory	Bourbonnais			
		Provena Pine View Care Center	St. Charles			
		Provena Geneva Care Center	Geneva			
		Provena Cor Mariae Center	Rockford			
		Provena St. Joseph Center	Freeport			
		Provena McAuley Manor	Aurora			
		Provena St. Anne Center	Rockford			

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	2	Food	$	Provena Life Connections	100.00%	$ 2,200	$ 2,200	1
2	V	5	Utilities		Provena Life Connections	100.00%	4,563	4,563	2
3	V	6	Maintenance - Other		Provena Life Connections	100.00%	1,123	1,123	3
4	V	11	Activities-Special Events		Provena Life Connections	100.00%	1,233	1,233	4
5	V	17	Admin - Misc. Other	476,004	Provena Life Connections	100.00%	4,288	(471,716)	5
6	V	17	Administrative Salaries		Provena Life Connections	100.00%	226,871	226,871	6
7	V	19	Professional Services		Provena Life Connections	100.00%	23,627	23,627	7
8	V	20	Dues,Subscriptions		Provena Life Connections	100.00%	5,314	5,314	8
9	V	21	Clerical Supplies		Provena Life Connections	100.00%	5,055	5,055	9
10	V	22	Employee Benefits		Provena Life Connections	100.00%	51,114	51,114	10
11	V	23	Education/Conference		Provena Life Connections	100.00%	2,841	2,841	11
12	V	24	Travel		Provena Life Connections	100.00%	3,113	3,113	12
13	V	26	Insurance		Provena Life Connections	100.00%	(369)	(369)	13
14	Total			$ 476,004			$ 330,973	$ * (145,031)	14

*** 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: 01/01/2011 Ending: 12/31/2011

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	30	Depreciation	$	Provena Life Connections	100.00%	$ 2,735	$ 2,735	15
16	V	32	Interest		Provena Life Connections	100.00%	187,561	187,561	16
17	V	34	Rent - Facility		Provena Life Connections	100.00%	14,286	14,286	17
18	V	35	Rent - Equipment		Provena Life Connections	100.00%	2,291	2,291	18
19	V	17	Admin Salaries	96,255	Provena Health Services	100.00%	73,260	(22,995)	19
20	V	22	Employee Benefits		Provena Health Services	100.00%	38,762	38,762	20
21	V	30	Depreciation		Provena Health Services	100.00%	38,396	38,396	21
22	V	19	Admin Consulting,Other		Provena Health Services	100.00%	16,078	16,078	22
23	V	17	Information Systems Salaries	118,645	Provena Health Services	100.00%	31,793	(86,852)	23
24	V	22	Information Systems Benefits		Provena Health Services	100.00%	23,385	23,385	24
25	V	17	Information Systems - Other		Provena Health Services	100.00%	21,532	21,532	25
26	V	17	Admin Salaries		Provena Health Services	100.00%	14,304	14,304	26
27	V	22	Employee Benefits		Provena Health Services	100.00%	19,178	19,178	27
28	V	17	Information Systems Salaries		Provena Health Services	100.00%	27,963	27,963	28
29	V	22	Information Systems Benefits		Provena Health Services	100.00%	28,099	28,099	29
30	V	6	Information Systems - Equip Maint		Provena Health Services	100.00%	57,081	57,081	30
31	V	32	Admin - Interest Expense		Provena Health Services	100.00%	121,663	121,663	31
32	V	39	Ancillary Services - Other	569,112	Provena Senior Services Pharmacy	100.00%	569,112		32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 784,012			$ 1,287,479	$ * 503,467	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: 01/01/2011 Ending: 12/31/2011

VII. RELATED PARTIES

A. (Continued) **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.**

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Provena Villa Franciscan	Joliet				1
2			Provena Heritage Village	Kankakee				2
3					Provena Clinics	Various	Physician's Clinics	3
4					Provena Fortin Villa	Bourbonnais	Childrens Center	4
5					Provena Fox Knoll	Aurora	Retirement Comm	5
6					Provena Health	Frankfort	Parent Company	6
7					Provena Home Care	Various	Home Health	7
8					Provena Home Equipment		Home Equipment	8
9					Provena Hospice	Various	Hospice	9
10					Provena Hospitals	Various	Hospital	10
11					Provena Laverna Te	Avilla, IN	Independent Livin	11
12					Provena Meadowvie	Kankakee	Supportive Living	12
13					Provena Senior Ser	Mokena	Management Con	13
14					Provena Senior Ser	Kankakee	Pharmacy	14
15					Provena St. Joseph	Freeport	Adult Day Care	15
16					Provena St. Mary's /	Kankakee	Adult Day Care	16
17					Provena St. Vincent	Freeport	Community Living	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

Facility Name & ID Number Provena Our Lady of Victory # 0041723 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		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: 01/01/2011 Ending: 2/31/2011

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 [X] NO [ ]

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

Name of Related Organization: Provena Life Connections
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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	Food	Management Fee Income	6,979,492	19	$ 32,265	$	476,004	$ 2,200	1
2	5	Utilities	Management Fee Income	6,979,492	19	66,913		476,004	4,563	2
3	6	Maintenance - Other	Management Fee Income	6,979,492	19	16,465		476,004	1,123	3
4	11	Activities-Special Events	Management Fee Income	6,979,492	19	18,086		476,004	1,233	4
5	17	Admin - Misc. Other	Management Fee Income	6,979,492	19	62,879		476,004	4,288	5
6	17	Administrative Salaries	Management Fee Income	6,979,492	19	3,326,538	3,326,538	476,004	226,871	6
7	19	Professional Services	Management Fee Income	6,979,492	19	346,433		476,004	23,627	7
8	20	Dues,Subscriptions	Management Fee Income	6,979,492	19	77,921		476,004	5,314	8
9	21	Clerical Supplies	Management Fee Income	6,979,492	19	74,124		476,004	5,055	9
10	22	Employee Benefits	Management Fee Income	6,979,492	19	749,474		476,004	51,114	10
11	23	Education/Conference	Management Fee Income	6,979,492	19	41,653		476,004	2,841	11
12	24	Travel	Management Fee Income	6,979,492	19	45,642		476,004	3,113	12
13	26	Insurance	Management Fee Income	6,979,492	19	(5,417)		476,004	(369)	13
14	30	Depreciation	Management Fee Income	6,979,492	19	40,099		476,004	2,735	14
15	32	Interest	Management Fee Income	6,979,492	19	2,750,151		476,004	187,561	15
16	34	Rent - Facility	Management Fee Income	6,979,492	19	209,473		476,004	14,286	16
17	35	Rent - Equipment	Management Fee Income	6,979,492	19	33,596		476,004	2,291	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 7,886,295	$ 3,326,538		$ 537,846	25

Facility Name & ID Number Provena Our Lady of Victory # 0041723 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Admin Salaries	Operating Expense	1,315,329	10	$ 1,001,096	$ 1,001,096	96,255	$ 73,260	1
2	22	Employee Benefits	Operating Expense	1,315,329	10	529,691		96,255	38,762	2
3	30	Depreciation	Operating Expense	1,315,329	10	524,686		96,255	38,396	3
4	34	Rent Facility	Operating Expense	1,315,329	10	219,709		96,255	16,078	4
5	19	Admin Consulting,Other	Operating Expense	1,315,329	10	434,452		96,255	31,793	5
6	17	Information Systems Salaries	Operating Expense	1,621,586	10	319,617	319,617	118,645	23,385	6
7	22	Information Systems Benefits	Operating Expense	1,621,586	10	294,294		118,645	21,532	7
8	17	Information Systems - Other	Operating Expense	1,621,586	10	195,496		118,645	14,304	8
9	17	Admin Salaries	Direct Cost	1,315,329	10	262,066	262,066	96,255	19,178	9
10	17	Information Systems Salaries	Direct Cost	1,621,586	10	382,190	382,190	118,645	27,963	10
11	6	Information Systems - Equip Mair	Direct Cost	1,621,586	10	384,039		118,645	28,099	11
12	19	Admin Consulting,Other	Direct Cost	1,315,329	10	780,014		96,255	57,081	12
13	32	Admin - Interest Expense	Direct Cost	1,315,329	10	1,662,527		96,255	121,663	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 6,989,877	$ 1,964,969		$ 511,494	25

Facility Name & ID Number Provena Our Lady of Victory # 0041723 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

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 [X] NO [ ]

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

Name of Related Organization: Provena Senior Services Pharmacy
Street Address: 670 North Convent Street
City / State / Zip Code: Bourbonnais, Illinois 60914
Phone Number: (815)936-3644
Fax Number: (815-936-3238

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	Ancillary Services - Other	Direct Allocation			$	$		$ 569,112	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					$	$		$ 569,112	25

Facility Name & ID Number Provena Our Lady of Victory # 0041723 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Home Office Allocation						$	$			$ 309,224	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 309,224	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$ 309,224	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:** 01/01/2011 **Ending:** 12/31/2011

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2006		8
	2007		9
	2008		10
	2009		11
	2010		12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2010	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

2010 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 2010 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 2010.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
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 and 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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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: 01/01/2011 Ending: 12/31/2011

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? [X] (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? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (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 [X] 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Home		1981	$ 135,000	1
2					2
3	TOTALS			$ 135,000	3

Facility Name & ID Number Provena Our Lady of Victory # 0041723 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	$	$	$ 507,122	4
5	8			1984	726,964		25			726,964	5
6	9			1987	33,355		15			33355	6
7	10			1995	2,520,706	64,282	35	64,282		1,060,031	7
8											8
	Improvement Type**										
9	Various			1982	95,473		17			95,473	9
10	Various			1984							10
11	Various			1985	300		12			300	11
12	Various			1986	45673		19			45673	12
13	Various			1987	14973		18			14973	13
14	Various			1988	6000		14			6000	14
15	Various			1989	1046		12			1046	15
16	Various			1990	88991		13			88991	16
17	Various			1991	16923		10			16923	17
18	Various			1992							18
19	Various			1993							19
20	Various			1994	3258		8			3258	20
21	Various			1995	8,996		5				21
22	Various			1996	192,299	8,721	11	8,721		160,262	22
23	Various			1997	81,139		6			81,139	23
24	Various			1998	44,576		6			44,576	24
25	Various			1999	74,075	2,159	6	2,159		68,678	25
26	Various			2000	25,153		7			25,153	26
27	Various			2001	105,322	4,079	7	4,079		105,322	27
28	Various			2002	64,880	4,219	9	4,219		59,551	28
29	Various			2003	169,078	12,911	10	12,911		110,443	29
30	Various			2004	219,895	12,834	10	12,834		116,840	30
31	Various			2005	75,584	6,548	9	6,548		54,053	31
32	Various			2006	55,599	4,898	11	4,898		34,488	32
33	Various			2007	23375	2829	9	2829		12995	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: 01/01/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	PARTIAL RE-ROOF	2008	$ 61,262	$ 6,126	10	$ 6,126	$	$ 21,442	37
38									38
39	PARTIAL RE-ROOF AND DECK	2009	63,025	6,303	10	6,303		15,756	39
40									40
41	(2) 5 TON AIR COOLED CONDENSING UNITS	2010	15,900	1,060	15	1,060		1,590	41
42	FIRE ALARMSMOKE/HEAT DETECTORS, PULL	2010	16,805	1,681	10	1,681		2,521	42
43	EMERGENCY POWER TOA,B,&C HALLS W/ PT	2010	74,560	7,456	10	7,456		11,184	43
44	EXHAUST HOOD SOUTHEND KITCHENETTE	2010	25,895	2,590		2,590		3,884	44
45									45
46	HOT WATER TANK	2011	10,995	275	20	550	275	275	46
47	BUILDING CARPETINGC/D	2011	54,951	5,495	5	10,990	5,495	5,495	47
48	AUTO DOOR OPEN AT MAIN	2011	9,237	462	10	924	462	462	48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	**TOTAL (lines 4 thru 69)**		$ 5,533,375	$ 154,927		$ 161,158	$ 6,232	$ 3,536,218	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: 01/01/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	$ 570,046	$ 60,289	$ 60,289	$	10	$ 251,609	71
72	Current Year Purchases	118,721	6,540	13,080	6,540	9	6,540	72
73	Fully Depreciated Assets	308,844				6	308,844	73
74	Home Office Allocation		41,131	41,131				74
75	TOTALS	$ 997,611	$ 107,960	$ 114,500	$ 6,540		$ 566,993	75

D. Vehicle Costs. (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 FORDELDORADO(CAPACITY 15)		$ 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)	$ 6,710,896	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 262,887	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 275,658	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 12,772	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,148,121	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.

Facility Name & ID Number Provena Our Lady of Victory # 0041723 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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				14,286			5
6								6
7	TOTAL				$ 14,286 **			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 ☒ X NO Terms: *

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.	/2012	$
13.	/2013	$
14.	/2014	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO
16. Rental Amount for movable equipment: $ 39,966 Description: Nursing $34,711; Administration $2,964; Home Office $2291
(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.

Facility Name & ID Number Provena Our Lady of Victory # 0041723 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Provena Our Lady of Victory

STATE OF ILLINOIS
0041723 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a,3	hrs	$	4,584	$ 314,765	$	4,584	$ 314,765	1
2	Licensed Speech and Language Development Therapist	10a,3	hrs		497	36,926		497	36,926	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a,3	hrs		5,173	364,072		5,173	364,072	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				569,112		569,112	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			$	10,254	$ 715,763	$ 569,112	10,254	$ 1,284,875	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.

STATE OF ILLINOIS

Facility Name & ID Number Provena Our Lady of Victory # 0041723 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2011 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 9,921,439	$	1
2	Cash-Patient Deposits	94,756		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	15,932,837		3
4	Supply Inventory (priced at)	788,723		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	202,376		7
8	Accounts Receivable (owners or related parties)	135,366		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 27,075,497	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	8,348,207		12
13	Land	6,027,432		13
14	Buildings, at Historical Cost	82,802,332		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	19,392,931		16
17	Accumulated Depreciation (book methods)	(58,282,720)		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):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 58,288,182	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 85,363,679	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 5,213,946	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,164,816		28
29	Short-Term Notes Payable	65,040		29
30	Accrued Salaries Payable	3,383,504		30
31	Accrued Taxes Payable (excluding real estate taxes)	136,208		31
32	Accrued Real Estate Taxes(Sch.IX-B)	1,389,718		32
33	Accrued Interest Payable	10,520		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to Related Party	983,226		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 12,346,978	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,037,972		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	396,894		42
	Other Long-Term Liabilities(specify):			
43	Conditional Asset Retirement	438,744		43
44	Deferred Lease Payable	23,814		44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,897,424	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 14,244,402	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 71,119,277	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 85,363,679	$	48

*(See instructions.)

Facility Name & ID Number Provena Our Lady of Victory # 0041723 **Report Period Beginning:** 01/01/2011 **Ending:** 12/31/2011

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 74,355,616	1
2	Restatements (describe):		2
3	**Transfer to Affiliates**	(8,169,570)	3
4	**Adj. To reconcile consolidated equity & consolidated income**	4,691,829	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 70,877,875	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	158,221	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	226,484	11
12	Expenditures for Specific Purposes	(143,303)	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)**	$ 241,402	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)**	$ 71,119,277	24 *

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

Facility Name & ID Number Provena Our Lady of Victory # 0041723 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,574,912	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,574,912	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,284,552	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,284,552	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	4,673	12
13	Barber and Beauty Care	6,641	13
14	Non-Patient Meals	2,687	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	470,606	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)**	$ 484,607	23
	D. Non-Operating Revenue		
24	Contributions	84,243	24
25	Interest and Other Investment Income***	14,540	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 98,783	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Purchase Rebates	276,331	28
28a	Misc. Income/Gain/Loss SOFA	(11,445)	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 264,886	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,707,740	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,211,359	31
32	Health Care	3,545,517	32
33	General Administration	1,940,229	33
	B. Capital Expense		
34	Ownership	224,719	34
	C. Ancillary Expense		
35	Special Cost Centers	569,112	35
36	Provider Participation Fee	58,583	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,549,519	40
41	**Income before Income Taxes (line 30 minus line 40)****	158,221	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 158,221	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: 01/01/2011 Ending: 12/31/2011

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,896	2,076	$ 75,816	$ 36.52	1
2	Assistant Director of Nursing	1,916	2,080	62,950	30.26	2
3	Registered Nurses	17,294	19,695	550,215	27.94	3
4	Licensed Practical Nurses	29,411	32,694	716,564	21.92	4
5	CNAs & Orderlies	59,988	66,392	756,830	11.40	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,123	8,175	112,996	13.82	8
9	Activity Director	1,864	2,080	35,115	16.88	9
10	Activity Assistants	2,902	3,142	29,581	9.41	10
11	Social Service Workers	3,413	4,068	59,130	14.54	11
12	Dietician	816	816	15,099	18.50	12
13	Food Service Supervisor	5,437	6,052	94,223	15.57	13
14	Head Cook					14
15	Cook Helpers/Assistants	19,953	21,603	198,449	9.19	15
16	Dishwashers					16
17	Maintenance Workers	5,445	5,985	92,705	15.49	17
18	Housekeepers	20,150	22,172	213,060	9.61	18
19	Laundry	384	392	4,134	10.55	19
20	Administrator	1,956	2,080	89,271	42.92	20
21	Assistant Administrator					21
22	Other Administrative	5,993	6,570	82,109	12.50	22
23	Office Manager					23
24	Clerical	3,849	4,241	66,035	15.57	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	2,041	2,501	36,611	14.64	31
32	Other Health C: Admissions	1,710	2,045	41,398	20.24	32
33	Other(specify) Pastoral Care	1,628	1,708	31,198	18.27	33
34	TOTAL (lines 1 - 33)	195,169	216,567	$ 3,363,489 *	$ 15.53	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	96	$ 7,200	1,3	35
36	Medical Director	65	9,750	9,3	36
37	Medical Records Consultant	25	1,735	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	13	806	11,3	44
45	Social Service Consultant	12	744	12,3	45
46	Other(specify)				46
47	MDS Coordinator	412	37,696	10,3	47
48					48
49	TOTAL (lines 35 - 48)	623	$ 57,931		49

C. CONTRACT NURSES

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

Facility Name & ID Number Provena Our Lady of Victory # 0041723 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Robin Gifford	Administrator	0	$ 89,271
Administrative Staff	Admissions	0	41,398
Administrative Staff	Human Resources	0	41,669
Administrative Staff	Bookkeeper	0	34,574
Administrative Staff	Receptionist	0	42,303
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 249,215

B. Administrative - Other

Description	Amount
Corporate Service Fee	$ 96,255
Corporate IS Fee	118,645
Mgmt Fee	275,100
Mgmt Fee Interest	200,904
TOTAL (agree to Schedule V, line 17, col. 3)	$ 690,904
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Legal Expense	Various	$ 1,043
Survey & Analytical Tools	Various	4,258
Shredding	Various	2,207
Outsourced Services	Various	1,139
Living Design	Various	833
Audit Expense	Various	(1,856)
Collection Fee	Various	659
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 8,283

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 92,229
Unemployment Compensation Insurance	24,379
FICA Taxes	242,437
Employee Health Insurance	349,379
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Life Insurance	13,317
Pension	109,376
Employee Recognition	741
Executive Benefits	3,659
Employment Screenings	21,562
Home Office Allocation	160,538
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,017,617

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 52)	
Patient Background Checks 121	
Employee Recruitment	2,268
Dues & Subscriptions	7,487
Advertising & Public Relations	1,439
Home Office Allocation	5,314
Less: Public Relations Expense	( )
Non-allowable advertising	(726)
Yellow page advertising	(408)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 15,374

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	837
Seminar Expense	
Home Office Allocation	3,113
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,950

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Provena Our Lady of Victory # 0041723 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Provena Our Lady of Victory **#** 0041723 **Report Period Beginning:** 01/01/2011 **Ending:** 12/31/2011

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 $5180**

(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? **No** If YES, what is the capacity? **N/A**

(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. $ **86,145** 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. $ **2,687**

(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.