FOR BHF USE

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2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

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: PRESENCE 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: 11-06-81

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 501C3

In the event there are further questions about this report, please contact:
Name: GEORGE VIEU **Telephone Number:** 708-478-7943
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 1/01/15 to 12/31/15 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, VICE PRESIDENT 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 PRESENCE OUR LADY OF VICTORY # 0041723 Report Period Beginning: 1/01/15 Ending: 12/31/15

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	24,105	3,923	5,471	33,499	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	24,105	3,923	5,471	33,499	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.77%

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 11-06-81

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 11-06-81 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 4,454

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: 12-31-15 Fiscal Year: 12-31-15

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

Facility Name & ID Number PRESENCE OUR LADY OF VICTORY # 0041723 Report Period Beginning: 1/01/15 Ending: 12/31/15

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

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY 9	10	
	A. General Services											
1	Dietary		22,117	516,178	538,295		538,295		538,295			1
2	Food Purchase		238,778		238,778		238,778	(273)	238,505			2
3	Housekeeping	137,035	19,674		156,709		156,709		156,709			3
4	Laundry	43,967	4,685		48,652		48,652		48,652			4
5	Heat and Other Utilities			150,352	150,352		150,352	1,711	152,063			5
6	Maintenance	82,976	11,656	110,309	204,941		204,941	24,562	229,503			6
7	Other (specify):* Pastoral	30,439	28	980	31,447		31,447		31,447			7
8	**TOTAL General Services**	294,417	296,938	777,819	1,369,174		1,369,174	26,000	1,395,174			8
	B. Health Care and Programs											
9	Medical Director			9,800	9,800		9,800		9,800			9
10	Nursing and Medical Records	2,411,185	214,674	110,916	2,736,775		2,736,775		2,736,775			10
10a	Therapy	107,599	29	365,647	473,275		473,275		473,275			10a
11	Activities	73,163	1,040	3,356	77,559		77,559	409	77,968			11
12	Social Services	66,452		1,874	68,326		68,326		68,326			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,658,399	215,743	491,593	3,365,735		3,365,735	409	3,366,144			16
	C. General Administration											
17	Administrative	231,480	4,261	718,443	954,184		954,184	206,389	1,160,573			17
18	Directors Fees											18
19	Professional Services			18,421	18,421		18,421	30,751	49,172			19
20	Dues, Fees, Subscriptions & Promotions			22,729	22,729		22,729	(2,744)	19,985			20
21	Clerical & General Office Expenses			15,215	15,215		15,215	(21,890)	(6,675)			21
22	Employee Benefits & Payroll Taxes			966,277	966,277		966,277	97,903	1,064,180			22
23	Inservice Training & Education			833	833		833	856	1,689			23
24	Travel and Seminar							1,035	1,035			24
25	Other Admin. Staff Transportation			1,588	1,588		1,588		1,588			25
26	Insurance-Prop.Liab.Malpractice			155,518	155,518		155,518	33,420	188,938			26
27	Other (specify):*											27
28	**TOTAL General Administration**	231,480	4,261	1,899,024	2,134,765		2,134,765	345,720	2,480,485			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,184,296	516,942	3,168,436	6,869,674		6,869,674	372,129	7,241,803			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 PRESENCE OUR LADY OF VICTORY #0041723 **Report Period Beginning:** 1/01/15 **Ending:** 12/31/15

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			384,319	384,319		384,319	(33,882)	350,437			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			180,714	180,714		180,714	86,604	267,318			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds							34,224	34,224			34
35	Rent-Equipment & Vehicles			97,353	97,353		97,353	583	97,936			35
36	Other (specify):*											36
37	**TOTAL Ownership**			662,386	662,386		662,386	87,529	749,915			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			205,017	205,017		205,017		205,017			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			232,586	232,586		232,586		232,586			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			437,603	437,603		437,603		437,603			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,184,296	516,942	4,268,425	7,969,663		7,969,663	459,658	8,429,321			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 PRESENCE OUR LADY OF VICTORY # 0041723 Report Period Beginning: 1/01/15 Ending: 12/31/15

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	(1,384)	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	5,109	30		9
10	Interest and Other Investment Income	(2,378)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(3,136)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(24,929)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (26,718)		$	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)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (26,718)		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

PRESENCE OUR LADY OF VICTORY

ID# 0041723

Report Period Beginning: 1/01/15

Ending: 12/31/15

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Development Misc	$ (24,929)	21	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**	(24,929)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number PRESENCE OUR LADY OF VICTORY # 0041723 **Report Period Beginning:** 1/01/15 **Ending:** 12/31/15

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	(1,384)	1,111	0	0	0	0	0	0	0	0	0	(273)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	1,711	0	0	0	0	0	0	0	0	0	1,711	5
6	Maintenance	0	2,723	21,839	0	0	0	0	0	0	0	0	24,562	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(1,384)	5,545	21,839	0	0	0	0	0	0	0	0	26,000	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	409	0	0	0	0	0	0	0	0	0	409	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	409	0	0	0	0	0	0	0	0	0	409	16
	C. General Administration													
17	Administrative	0	(84,311)	290,700	0	0	0	0	0	0	0	0	206,389	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	30,751	0	0	0	0	0	0	0	0	0	30,751	19
20	Fees, Subscriptions & Promotions	(3,136)	392	0	0	0	0	0	0	0	0	0	(2,744)	20
21	Clerical & General Office Expenses	(24,929)	3,039	0	0	0	0	0	0	0	0	0	(21,890)	21
22	Employee Benefits & Payroll Taxes	0	35,697	62,206	0	0	0	0	0	0	0	0	97,903	22
23	Inservice Training & Education	0	856	0	0	0	0	0	0	0	0	0	856	23
24	Travel and Seminar	0	1,035	0	0	0	0	0	0	0	0	0	1,035	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	33,420	0	0	0	0	0	0	0	0	0	33,420	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(28,065)	20,879	352,906	0	0	0	0	0	0	0	0	345,720	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(29,449)	26,833	374,745	0	0	0	0	0	0	0	0	372,129	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number PRESENCE OUR LADY OF VICTORY # 0041723 **Report Period Beginning:** 1/01/15 **Ending:** 12/31/15

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

	Capital Expense D. Ownership	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)	
30	Depreciation	5,109	0	(38,991)	0	0	0	0	0	0	0	0	(33,882)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,378)	0	88,982	0	0	0	0	0	0	0	0	86,604	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	34,224	0	0	0	0	0	0	0	0	34,224	34
35	Rent-Equipment & Vehicles	0	0	583	0	0	0	0	0	0	0	0	583	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	2,731	0	84,798	0	0	0	0	0	0	0	0	87,529	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	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(26,718)	26,833	459,543	0	0	0	0	0	0	0	0	459,658	45

Facility Name & ID Number PRESENCE OUR LADY OF VICTORY # 0041723 Report Period Beginning: 1/01/15 Ending: 12/31/15

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
		Presence Our Lady of Victory	Bourbonnais	Presence Service Corp	Various	Physician's Clinics
		Presence Pine View Care Center	St. Charles	Presence Fortin Villa I	Bourbonnais	Childrens Center
		Presence Cor Mariae Center	Rockford	Presence Fox Knoll	Aurora	Retirement Comm
		Presence St. Joseph Center	Freeport	Presence Health	Chicago	Parent Company
		Presence McAuley Manor	Aurora	Presence Home Care	Various	Home Health
		Presence St. Anne Center	Rockford	Presence Care @ Hom	Various	Home Equipment
		Presence Villa Franciscan	Joliet	Presence Hospice	Various	Hospice

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	$	Presence Life Connections	100.00%	$ 1,111	$ 1,111	1
2	V	5	Utilities		Presence Life Connections	100.00%	1,711	1,711	2
3	V	6	Maintenance - Other		Presence Life Connections	100.00%	2,723	2,723	3
4	V	11	Activities-Special Events		Presence Life Connections	100.00%	409	409	4
5	V	17	Admin - Misc. Other	272,687	Presence Life Connections	100.00%	10,269	(262,418)	5
6	V	17	Administrative Salaries		Presence Life Connections	100.00%	178,107	178,107	6
7	V	19	Professional Services		Presence Life Connections	100.00%	30,751	30,751	7
8	V	20	Dues,Subscriptions		Presence Life Connections	100.00%	392	392	8
9	V	21	Clerical Supplies		Presence Life Connections	100.00%	3,039	3,039	9
10	V	22	Employee Benefits		Presence Life Connections	100.00%	35,697	35,697	10
11	V	23	Education/Conference		Presence Life Connections	100.00%	856	856	11
12	V	24	Travel		Presence Life Connections	100.00%	1,035	1,035	12
13	V	26	Insurance		Presence Life Connections	100.00%	33,420	33,420	13
14	Total			$ 272,687			$ 299,520	$ * 26,833	14

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

Facility Name & ID Number PRESENCE OUR LADY OF VICTORY # 0041723 Report Period Beginning: 1/01/15 Ending: 12/31/15

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	$	Presence Life Connections	100.00%	$ 3,199	$ 3,199	15
16	V	32	Interest		Presence Life Connections	100.00%	0		16
17	V	34	Rent - Facility		Presence Life Connections	100.00%	16,000	16,000	17
18	V	35	Rent - Equipment		Presence Life Connections	100.00%	583	583	18
19	V	17	Admin Salaries		Presence Health	100.00%	102,561	102,561	19
20	V	22	Employee Benefits		Presence Health	100.00%	62,206	62,206	20
21	V	30	Depreciation	84,411	Presence Health	100.00%	42,221	(42,190)	21
22	V	34	Rent Facility		Presence Health	100.00%	18,224	18,224	22
23	V	17	Admin Consulting,Other	445,756	Presence Health	100.00%	378,401	(67,355)	23
24	V	17	Information Systems Salaries		Presence Health	100.00%	36,368	36,368	24
25	V	17	Information Systems - Other		Presence Health	100.00%	129,941	129,941	25
26	V	17	Admin Salaries		Presence Health	100.00%	30,058	30,058	26
27	V	17	Information Systems Salaries		Presence Health	100.00%	41,445	41,445	27
28	V	6	Information Systems - Equip Maint		Presence Health	100.00%	21,839	21,839	28
29	V	17	Admin Consulting,Other		Presence Health	100.00%	17,682	17,682	29
30	V	32	Admin - Interest Expense		Presence Health	100.00%	88,982	88,982	30
31	V	39	Ancillary Services - Other	205,017	Presence Senior Services Pharmacy	100.00%	205,017		31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 735,184			$ 1,194,727	$ * 459,543	39

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

Facility Name & ID Number PRESENCE OUR LADY OF VICTORY # 0041723 Report Period Beginning: 1/01/15 Ending: 12/31/15

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	Jean Blake	BOD	Presence Heritage Village	Kankakee	Presence Hospitals	Various	Hospital	1
2	Nancy Dowd	BOD	Presence Maryhaven Nursing & Rehab Center	Glenview	Laverna Terrace Hous	Avilla, IN	Independent Living	2
3	James Hagen	BOD	Presence Nazarethville	Des Plaines	Presence Heritage Lod	Kankakee	Supportive Living	3
4	Lucia Jones	BOD	Presence Resurrection Life Center	Chicago	Presence Life Connect	Mokena	Management Comp.	4
5	Theresa Kwiatkowski	BOD	Presence Resurrection Nursing & Rehab Center	Park Ridge	Presence Senior Servic	Kankakee	Pharmacy	5
6	Joseph Hugar	BOD	Presence St Benedict Nursing & Rehab Center	Niles	Presence St. Joseph Ac	Freeport	Adult Day Care	6
7	John Larson	BOD	Presence Villa Scalabrini Nursing & Rehab Cen	Northlake	Presence Heritage Day	Kankakee	Adult Day Care	7
8	Sr Marie Mason	BOD			Presence St. Vincent	Freeport	Community Living	8
9	Sallie Miller	BOD			Presence Behavioral H	Broadview	Parent	9
10	Phyllis Nichols	BOD			Presence Holy Family	Des Plaines	Hospital	10
11	Lawrence Pankau, MD	BOD			Presence Bethlehem W	LaGrange Park	Independent Living	11
12	Tim Phillippe	BOD			Presence Our Lady of	Chicago	Hospital	12
13	Thomas Smith	BOD			Presence Casa San Ca	Northlake	Independent Living	13
14		BOD			Presence Ambulatory	Various	Parent	14
15					Resurrection Developr	Chicago	Parent	15
16					Presence Healthcare S	Various	Parent	16
17					Presence Health Care	Various	Physicians	17
18					Presence Home Care S	Various	Home Health	18
19					Presence Resurrection	Chicago	Hospital	19
20					Resurrection Services	Des Plaines	Parent	20
21					Presence Saint Francis	Evanston	Hospital	21
22					Presence Saint Joseph	Chicago	Hospital	22
23					Presence Saints Mary	Chicago	Hospital	23
24					Resurrection Retireme	Chicago	Independent Living	24
25					Resurrection Universit	Chicago	College	25
26					Presence Health Partn	Various	Parent	26
27					Presence Properties PI	Bolingbrook	Parent	27
28					Presence Ventures, Inc	Bolingbrook	Parent	28
29					Presence Heritage Esta	Kankakee	Independent Living	29
30								30

Facility Name & ID Number PRESENCE OUR LADY OF VICTORY # 0041723 Report Period Beginning: 1/01/15 Ending: 12/31/15

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	NA								$		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 PRESENCE OUR LADY OF VICTORY # 0041723 Report Period Beginning: 1/01/15 Ending: 12/31/15

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: Presence Life Connections
Street Address: 18927 Hickory Creek Dr, Ste 300
City / State / Zip Code: Mokena, IL 60448
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	7,761,581	27	$ 31,634	$	272,687	$ 1,111	1
2	5	Utilities	Management Fee Income	7,761,581	27	48,706		272,687	1,711	2
3	6	Maintenance - Other	Management Fee Income	7,761,581	27	77,498		272,687	2,723	3
4	11	Activities-Special Events	Management Fee Income	7,761,581	27	11,644		272,687	409	4
5	17	Admin - Misc. Other	Management Fee Income	7,761,581	27	292,301		272,687	10,269	5
6	17	Administrative Salaries	Management Fee Income	7,761,581	27	5,069,517	5,069,517	272,687	178,107	6
7	19	Professional Services	Management Fee Income	7,761,581	27	875,274		272,687	30,751	7
8	20	Dues,Subscriptions	Management Fee Income	7,761,581	27	11,166		272,687	392	8
9	21	Clerical Supplies	Management Fee Income	7,761,581	27	86,492		272,687	3,039	9
10	22	Employee Benefits	Management Fee Income	7,761,581	27	1,016,065		272,687	35,697	10
11	23	Education/Conference	Management Fee Income	7,761,581	27	24,366		272,687	856	11
12	24	Travel	Management Fee Income	7,761,581	27	29,466		272,687	1,035	12
13	26	Insurance	Management Fee Income	7,761,581	27	951,237		272,687	33,420	13
14	30	Depreciation	Management Fee Income	7,761,581	27	91,051		272,687	3,199	14
15	32	Interest	Management Fee Income	7,761,581	27	0		272,687	0	15
16	34	Rent - Facility	Management Fee Income	7,761,581	27	455,407		272,687	16,000	16
17	35	Rent - Equipment	Management Fee Income	7,761,581	27	16,606		272,687	583	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 9,088,430	$ 5,069,517		$ 319,302	25

Facility Name & ID Number PRESENCE OUR LADY OF VICTORY # 0041723 Report Period Beginning: 1/01/15 Ending: 12/31/15

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: Presence Health
Street Address: 100 North River Road
City / State / Zip Code: Des Plaines, IL 60016
Phone Number: (815-806-2327
Fax Number: ( )

	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	5,977,354	17	$ 1,375,283	$ 1,375,283	445,756	$ 102,561	1
2	22	Employee Benefits	Operating Expense	5,977,354	17	834,149		445,756	62,206	2
3	30	Depreciation	Operating Expense	1,607,196	17	803,889		84,411	42,221	3
4	34	Rent Facility	Operating Expense	5,977,354	17	244,378		445,756	18,224	4
5	17	Admin Consulting,Other	Operating Expense	5,977,354	17	5,074,164		445,756	378,401	5
6	17	Information Systems Salaries	Operating Expense	5,977,354	17	487,675	487,675	445,756	36,368	6
7	17	Information Systems - Other	Operating Expense	5,977,354	17	1,742,443		445,756	129,941	7
8	17	Admin Salaries	Direct Cost	5,977,354	17	403,064	403,064	445,756	30,058	8
9	17	Information Systems Salaries	Direct Cost	5,977,354	17	555,758	555,758	445,756	41,445	9
10	6	Information Systems - Equip Mai	Direct Cost	5,977,354	17	292,852		445,756	21,839	10
11	17	Admin Consulting,Other	Direct Cost	5,977,354	17	237,106		445,756	17,682	11
12	32	Admin - Interest Expense	Direct Cost	5,977,354	17	1,193,207		445,756	88,982	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					$ 13,243,968	$ 2,821,780		$ 969,928	25

Facility Name & ID Number PRESENCE OUR LADY OF VICTORY # 0041723 Report Period Beginning: 1/01/15 Ending: 12/31/15

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: Presence Senior Services Pharmacy
Street Address: 670 North Convent Street
City / State / Zip Code: Bourbonnais, Illinois 60614
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			$	$		$ 205,017	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					$	$		$ 205,017	25

Facility Name & ID Number PRESENCE OUR LADY OF VICTORY # 0041723 Report Period Beginning: 1/01/15 Ending: 12/31/15

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						$	$			$ 88,982	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 88,982	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$ 88,982	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** NA **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 PRESENCE OUR LADY OF VICTORY # 0041723 **Report Period Beginning:** 1/01/15 **Ending:** 12/31/15

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 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 2015 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:		
	2010	8
	2011	9
	2012	10
	2013	11
	2014	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2014	$	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.

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME PRESENCE 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 2014 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 2014.

	(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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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 PRESENCE OUR LADY OF VICTORY # 0041723 Report Period Beginning: 1/01/15 Ending: 12/31/15

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. [ ] (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 PRESENCE OUR LADY OF VICTORY # 0041723 Report Period Beginning: 1/01/15 Ending: 12/31/15

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	$	$	$ 507,112	4
5	8			1984	726,964		25			726,964	5
6	9			1987	33,355		15			33,355	6
7	10			1995	2,520,706	64,282	35	64,282		1,308,020	7
8											8
	Improvement Type**										
9	VARIOUS			1982	95,473		25			95,473	9
10	VARIOUS			1987	52,453		21			52,453	10
11	VARIOUS			1989	1,046		15			1,046	11
12	VARIOUS			1990	88,991		15			88,991	12
13	VARIOUS			1994	3,258		8			3,258	13
14	VARIOUS			1995	3,865		7			3,865	14
15	VARIOUS			1996	71,099	1,212	8	1,212		69,987	15
16	VARIOUS			1997	207,304	4,320	8	4,320		202,138	16
17	VARIOUS			1998	44,742		5			44,742	17
18	VARIOUS			1999	74,075		6			74,075	18
19	VARIOUS			2000	16,853		6			16,853	19
20	VARIOUS			2001	37,182		7			37,182	20
21	VARIOUS			2002	90,550	308	9	308		90,165	21
22	VARIOUS			2003	219,848	4,198	10	4,198		194,782	22
23	VARIOUS			2004	222,535	10,218	10	10,218		166,971	23
24	VARIOUS			2005	78,192	209	9	209		76,369	24
25	VARIOUS			2006	50,352	2,739	12	2,739		41,134	25
26	VARIOUS			2007	23,375	1,601	8	1,601		20,788	26
27	VARIOUS			2008	61,262	5,951	10	5,951		45,888	27
28	VARIOUS			2009	63,025	5,685	10	5,685		40,760	28
29	VARIOUS			2010	133,160	12,352	11	12,352		70,178	29
30	VARIOUS			2011	75,183	9,262	12	9,262		55,019	30
31											31
32	ELECTRICAL & CONRTL INSTALL ERV UNIT			2012	2,834	142	20	142		495	32
33	FURNISH AND INSTALL 3 CARRIER ENERGY			2012	13,960	698	20	698		2,438	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 PRESENCE OUR LADY OF VICTORY # 0041723 Report Period Beginning: 1/01/15 Ending: 12/31/15

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	FIRE ALARM	2013	$ 8,983	$ 898	10	$ 898	$	$ 2,234	37
38	KITCHEN HOOD ELECTRIC	2013	3,537	354	10	354		882	38
39	TANDEM MAGNETIC LOCKS	2013	2,915	292	10	292		725	39
40									40
41	AIR COMPRESSOR INRISOR ROOM RE	2014	5,819	485	12	485		727	41
42	CABINETS COUNTERTOPS	2014	2,689	179	15	179		446	42
43	COURT YARD DOOR	2014	12,582	839	15	839		2,087	43
44	FLOORING	2014	84,509	8,451	10	8,451		20,958	44
45	LIGHTING FIXTURES	2014	42,921	4,292	10	4,292		10,644	45
46	OVERHEAD DOOR STOPS WAINSCOTTI	2014	33,233	2,216	15	2,216		3,332	46
47	PLUMBING	2014	76,500	3,825	20	3,825		5,760	47
48	NEW SIDE WALKS	2014	14,800	1,850	8	1,850		2,753	48
49	LIGHTING IN CENTRAL NU	2014	10,612	1,061	10	1,061		1,582	49
50	RESIDENT ROOM DOOR	2014	92,126	6,142	15	6,142		15,278	50
51	ROOM PAINTING	2014	8,500	1,700	5	1,700		4,165	51
52	WALL PAINTING	2014	14,700	2,940	5	2,940		3,734	52
53	WIRELESS CALL SYSTEM	2014	54,444	5,444	10	5,444		8,117	53
54									54
55	PAINT AND REPAIR WALLS OF ALL BATHROOMS IN BLDG	2015	10,250	1,879	5	2,050	171	1,879	55
56	BEDROOM FURNITURE	2015	39,796	1,327	20	1,990	663	1,327	56
57	NEW HANDRAILS FOR ENTRYWAY AND HALLWAYS	2015	33,975	1,510	15	2,265	755	1,510	57
58	LABOR FOR INSTALLATION OF LIGHTS IN ADMIN AREA	2015	2,211	219	15	147	(72)	219	58
59	LIGHTING FIXTURES AND EQUIPMENT IN ADMIN AREA	2015	3,024	299	15	202	(98)	299	59
60	LIGHT FIXTURES IN RESIDENT COMMON AREAS/ROOMS	2015	18,880	503	25	755	252	503	60
61	MATTRESS, ADV CONTOUR 3.3, 36X	2015	8,903	41	18	495	453	41	61
62	MATTRESS, LOW AIR, ALT PRESS,	2015	6,890	32	18	383	351	32	62
63	DESKS/CHAIRS/FLOORING/COUNTERS FOR NURSE STN	2015	12,953	540	20	648	108	540	63
64	SIDEWALKS	2015	52,400	3,202	15	3,493	291	3,202	64
65	TUB AND SINK FAUCETS/HANDLES FOR BATHROOMS	2015	23,850	1,424	25	954	(470)	1,424	65
66	COUNTERS CABINETS IN FOOD PREPARATION AREA	2015	5,323	325	15	355	30	325	66
67	NEW FLOORING IN DINING ROOM	2015	100,223	4,685	30	6,682	1,997	4,685	67
68	WIRELESS CALL SYSTEM	2015	34,365	4,254	12	2,864	(1,390)	4,254	68
69									69
70	TOTAL (lines 4 thru 69)		$ 6,340,666	$ 184,386		$ 187,426	$ 3,041	$ 4,174,167	70

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

Facility Name & ID Number PRESENCE OUR LADY OF VICTORY # 0041723 Report Period Beginning: 1/01/15 Ending: 12/31/15

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	$ 992,826	$ 101,268	$ 101,268	$	12	$ 470,975	71
72	Current Year Purchases	30,193	283	2,351	2,069	13	283	72
73	Fully Depreciated Assets	432,869				7	432,869	73
74	Home Office Allocation		84,411	84,411				74
75	TOTALS	$ 1,455,888	$ 185,961	$ 188,030	$ 2,069		$ 904,127	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 FORD ELDORADO	1999	$ 44,910	$	$	$	8	$ 44,910	76
77	PLANT ENGINEERING	2013 FORD STARCRAFT	2013	55,889	13,972	13,972		4	36,300	77
78										78
79										79
80	TOTALS			$ 100,799	$ 13,972	$ 13,972	$		$ 81,210	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)	$ 8,032,353	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 384,319	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 389,428	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 5,109	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 5,159,504	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 PRESENCE OUR LADY OF VICTORY # 0041723 Report Period Beginning: 1/01/15 Ending: 12/31/15

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				34,224			5
6								6
7	TOTAL				$ 34,224 **			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: *

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.	/2016	$
13.	/2017	$
14.	/2018	$

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: $ 97,936 Description: Administration 4320, Dietary 390, Hskpg 30, Nursing 88723, Home Office
    (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 PRESENCE OUR LADY OF VICTORY # 0041723 Report Period Beginning: 1/01/15 Ending: 12/31/15

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 PRESENCE OUR LADY OF VICTORY # 0041723 Report Period Beginning: 1/01/15 Ending: 12/31/15

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

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service		Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a,1&3	1386	hrs	$ 52,624	2,084	$ 126,793	$	3,470	$ 179,417	1
2	Licensed Speech and Language Development Therapist	10a,1&3		hrs		624	39,678		624	39,678	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10a,1&3	1488	hrs	54,975	2,556	155,274		4,044	210,249	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				205,017		205,017	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				$ 107,599	5,264	$ 321,745	$ 205,017	8,138	$ 634,361	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number PRESENCE OUR LADY OF VICTORY # 0041723 Report Period Beginning: 1/01/15 Ending: 12/31/15

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/15 (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	$ 15,116,271	$	1
2	Cash-Patient Deposits	142,276		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	38,985,402		3
4	Supply Inventory (priced at)	1,405,559		4
5	Short-Term Investments	1,530,325		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	1,822,954		7
8	Accounts Receivable (owners or related parties)	2,119,287		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 61,122,074	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	13,185,056		12
13	Land	17,252,477		13
14	Buildings, at Historical Cost	235,676,159		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	69,751,494		16
17	Accumulated Depreciation (book methods)	(179,552,982)		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):	397,300		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 156,709,504	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 217,831,578	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 13,801,729	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	26,484,204		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	3,400		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	1,921,984		32
33	Accrued Interest Payable	6,273		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to Third Parties	(1,674,742)		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 40,542,848	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,286,073		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Conditional Asset Retirement	99,654		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,385,727	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 41,928,575	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 175,903,003	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 217,831,578	$	48

***(See instructions.)**

Facility Name & ID Number PRESENCE OUR LADY OF VICTORY # 0041723 Report Period Beginning: 1/01/15 Ending: 12/31/15

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 73,167,735	1
2	Restatements (describe):		2
3			3
4	**Adj. to reconcile consolidated equity & consolidated income**	103,860,347	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 177,028,082	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,591,531)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	1,437,836	11
12	Expenditures for Specific Purposes	(971,384)	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)**	$ (1,125,079)	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)**	$ 175,903,003	24 *

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

Facility Name & ID Number PRESENCE OUR LADY OF VICTORY # 0041723 Report Period Beginning: 1/01/15 Ending: 12/31/15

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,882,704	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,882,704	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	923,388	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 923,388	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		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	1,384	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	444,750	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)**	$ 446,134	23
	D. Non-Operating Revenue		
24	Contributions	123,528	24
25	Interest and Other Investment Income***	2,378	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 125,906	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income		28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,378,132	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,369,174	31
32	Health Care	3,365,735	32
33	General Administration	2,134,765	33
	B. Capital Expense		
34	Ownership	662,386	34
	C. Ancillary Expense		
35	Special Cost Centers	205,017	35
36	Provider Participation Fee	232,586	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,969,663	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,591,531)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,591,531)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,700,908	44
45	Private Pay - Net Inpatient Revenue	171,410	45
46	Medicare - Net Inpatient Revenue	857,134	46
47	Other-(specify) Insurance	153,252	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,882,704	49

* **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 PRESENCE OUR LADY OF VICTORY # 0041723 Report Period Beginning: 1/01/15 Ending: 12/31/15

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	2,025	2,230	$ 79,009	$ 35.43	1
2	Assistant Director of Nursing	1,578	1,724	55,142	31.98	2
3	Registered Nurses	29,976	32,348	737,113	22.79	3
4	Licensed Practical Nurses	31,449	34,468	672,606	19.51	4
5	CNAs & Orderlies	69,368	74,140	714,670	9.64	5
6	CNA Trainees					6
7	Licensed Therapist	2,735	2,874	107,599	37.44	7
8	Rehab/Therapy Aides	7,054	7,670	107,054	13.96	8
9	Activity Director	1,901	2,103	38,289	18.21	9
10	Activity Assistants	4,397	4,811	47,187	9.81	10
11	Social Service Workers	2,901	3,323	50,302	15.14	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	16,628	18,195	201,500	11.07	17
18	Housekeepers					18
19	Laundry	3,820	4,268	43,705	10.24	19
20	Administrator	1,758	1,919	105,587	55.02	20
21	Assistant Administrator					21
22	Other Administrative	676	731	10,895	14.90	22
23	Office Manager	698	780	15,211	19.50	23
24	Clerical	7,219	7,930	90,210	11.38	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	2,344	2,478	41,823	16.88	31
32	Other Health C: Admissions	1,735	1,914	35,955	18.79	32
33	Other(specify) Pastoral	1,527	1,648	30,439	18.47	33
34	TOTAL (lines 1 - 33)	189,789	205,554	$ 3,184,296 *	$ 15.49	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	29	$ 1,626	1,3	35
36	Medical Director	Monthly	9,800	9,3	36
37	Medical Records Consultant	22	1,602	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	15	984	11,3	44
45	Social Service Consultant	29	1,907	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	95	$ 15,919		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	41	$ 2,497	10,2	50
51	Licensed Practical Nurses	124	5,118	10,2	51
52	Certified Nurse Assistants/Aides	366	8,867	10,2	52
53	TOTAL (lines 50 - 52)	531	$ 16,482		53

Facility Name & ID Number PRESENCE OUR LADY OF VICTORY # 0041723 Report Period Beginning: 1/01/15 Ending: 12/31/15

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Robin Gifford	Administrator		$ 105,587
Admnistrative Staff	Office Manager		15,211
Admnistrative Staff	Receptionists		57,356
Admnistrative Staff	Admissions		35,997
Admnistrative Staff	Other Administration		17,329
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 231,480

B. Administrative - Other

Description	Amount
Corp Office Management Fee	$ 718,443
TOTAL (agree to Schedule V, line 17, col. 3)	$ 718,443
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Legal	Various	$ 1,675
Survey & Analytical Tools	Various	1,485
Shredding	Various	1,423
Outsourced Services	Various	2,272
Volunteer Program	Various	5,830
Collection Fee	Various	38
Aviaries	Various	922
Courier Service	Various	4,712
Outside Printing	Various	64
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 18,421

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 64,690
Unemployment Compensation Insurance	13,699
FICA Taxes	230,396
Employee Health Insurance	416,883
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Home Office Allocation	97,903
Dental	10,726
Life Insurance	2,244
Disability Insurance	19,232
Pension	180,940
Tuition Reimbursement	11,558
Other Benefits	15,909
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,064,180

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 53)	
Patient Background Checks 151	
Employee Recruitment	12,419
Dues & Subscription	7,174
Advertising & Public Relations	3,136
Home Office Allocation	392
Less: Public Relations Expense	( )
Non-allowable advertising	(3,136)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 19,985

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	0
Seminar Expense	
Home Office Allocation	1,035
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,035

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number PRESENCE OUR LADY OF VICTORY # 0041723 Report Period Beginning: 1/01/15 Ending: 12/31/15

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 PRESENCE OUR LADY OF VICTORY # 0041723 Report Period Beginning: 1/01/15 Ending: 12/31/15

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. **LEADING AGE $4891.15**

(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? **13**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **47,555** 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. $ **232,586**
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. $ **NONE** Has any meal income been offset against related costs? **YES** Indicate the amount. $ **1,384**

(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) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **YES**
Attach invoices and a summary of services for all architect and appraisal fees.